HOSPITALS

JOURNAL OF THE
AMERICAN HOSPITAL ASSOCIATION

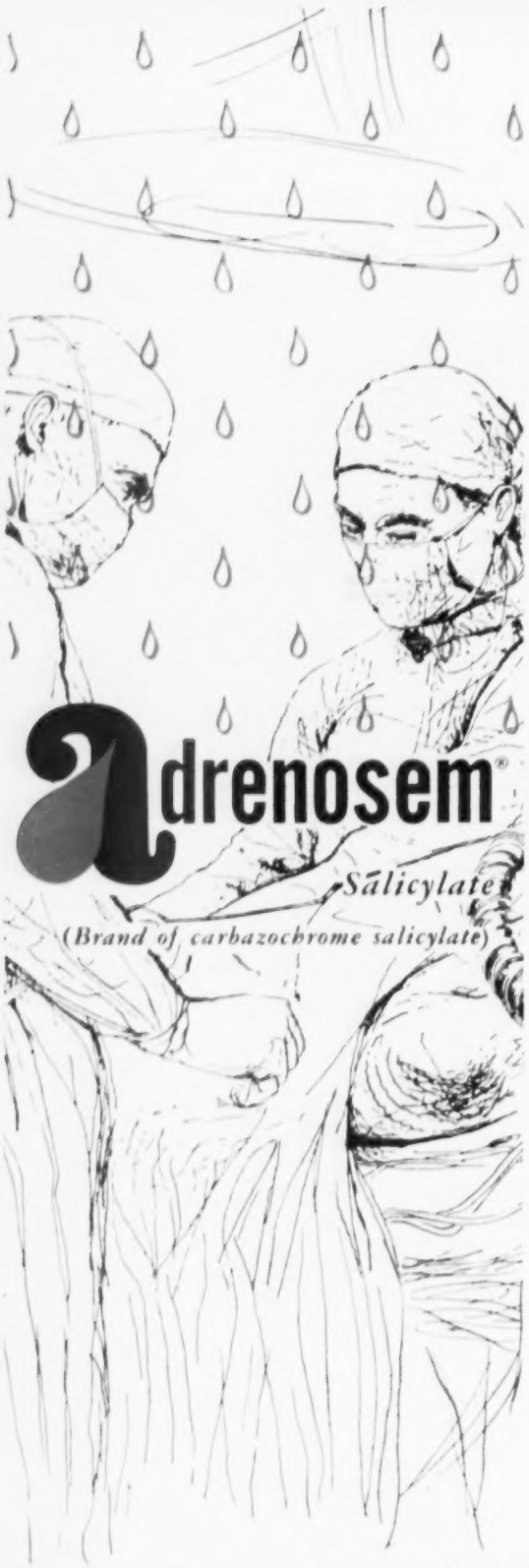
OCTOBER 1, 1956

convention report issue

TOL TERRELL
AHA PRESIDENT-ELECT

TEXAS

Hospital, Address, Telephone, Administrator, Approvals, Facilities	Classification: Ownership	Classification: Length of Stay	Classification: Type of Service	Inpatient Data: Beds	Inpatient Data: Admissions	Inpatient Data: Average Daily Census	Newborn Data: Bassinets	Newborn Data: Births	Newborn Data: Newborn Census	Expenses (000 omitted): Total	Expenses (000 omitted): Payroll	Personnel: Paid (excl. Int., Res., Studt.)	Personnel: Intern, Resident, Student
★ indicates membership in the American Hospital Association. For definitions, numerical codes and abbreviations see *Key to Listing* facing page 85.													
SAN ANGELO—Tom Green County													
• SHANNON WEST TEXAS MEMORIAL Est 1932—9 S Magdalen—Tel 21461—B, Tol Terrell, Adm.—A-1-3-6-7-8—F-1-2-3-4-6-8-9-10-12-13-14-16-18-19-21	23	1	1	144	5690	107	18	691	7	1119	672	255	73



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1. *Bacala, J.C.: The Use of the Systemic Hemostat Carbazochrome Salicylate, West. J. Surg. 64:88 (1956).*

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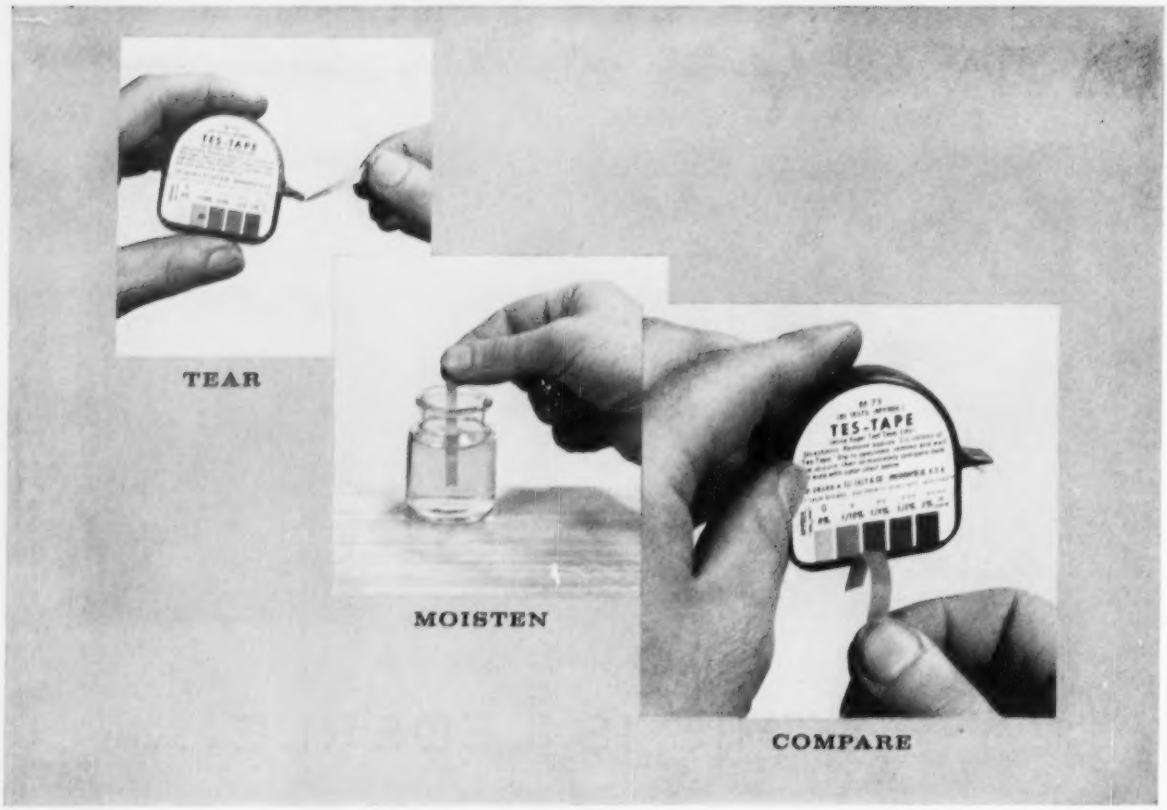

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hospitals

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cover

Tol Terrell, administrator of Shannon West Texas Memorial Hospital, San Angelo, and president-elect of the American Hospital Association, will become the 59th AHA president when he assumes that position in September, 1957. Photo by Robert M. McCullough. (Other picture credits on p. 134.)

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1. Bogash, R.C., and Pisanelli, R.: Hosp. Management 80:82 (Nov.-Dec.) 1955. 2. Hunter, J.A., et al.: Hosp. Management 81:82 (March) 1956. 3. Hunter, J.A., et al.: Hosp. Management 81:80 (Apr.) 1956.

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American Protestant Hospital Association—February 27-March 1; Chicago (Palmer House)
Catholic Hospital Association—May 27-30; Cleveland, Ohio (Hotel Statler)

REGIONAL MEETINGS

(THROUGH SEPTEMBER 1957)

Association of Western Hospitals—May 6-9; Los Angeles (Statler Hotel)
Carolinas-Virginias Hospital Conference—April 11-12; Roanoke (Hotel Roanoke)
Maryland-District of Columbia-Delaware Hospital Association — October 31, November 1-2; Washington, D. C. (Shoreham Hotel)
Middle Atlantic Hospital Assembly—May 22-24; Atlantic City (Convention Hall)
Mid-West Hospital Association — April 24-26; Kansas City, Mo. (Hotel President)
New England Hospital Assembly—March 25-27; Boston (Statler Hotel)
Southeastern Hospital Conference—April 24-26; Atlanta (Atlanta Biltmore Hotel)
Tri-State Hospital Assembly—April 29-May 2; Chicago (Palmer House)
Upper Midwest Hospital Conference—May 22-24; Minneapolis (Hotel Leamington)

STATE AND PROVINCIAL MEETINGS

(THROUGH MARCH 1957)

Alabama Hospital Association—January 24-25; Montgomery (Whitley Hotel)
Associated Hospitals of Alberta—October 16-18; Edmonton (MacDonald Hotel)
Arizona Hospital Association—November 15-17; Phoenix (Westward Ho Hotel)
California Hospital Association—October 24-26; San Jose (St. Claire Hotel)
Colorado Hospital Association—November 7-8; Colorado Springs (Broadmoor Hotel)
Connecticut Hospital Association—November 15; New Haven (So. New England Telephone Co. Aud.)
Florida Hospital Association—November 29-30; Jacksonville (George Washington Hotel)
Idaho Hospital Association—October 22-23; Boise (Hotel Boise)
Illinois Hospital Association—December 6-7; Springfield (Hotel Abraham Lincoln)
Indiana Hospital Association—October 24-25; Indianapolis (Student Union Building, University of Indiana Medical Center)
Kansas Hospital Association—November 15-16; Hutchinson (Baker Hotel)
Kentucky Hospital Association—March 26-28; Lexington (Hotel Phoenix)
Associated Hospitals of Manitoba—October 29-November 1; Winnipeg (Royal Alexandra Hotel)
Minnesota Hospital Association — November 9; St. Paul (Hotel St. Paul)
Mississippi Hospital Association—October 18-19; Jackson (Edwards Hotel)
Missouri Hospital Association—November 8-9; St. Louis (Hotel Jefferson)
Montana Hospital Association—October 10-12; Missoula (Florence Hotel)
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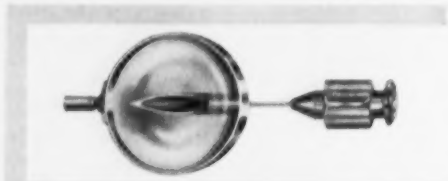
Ohio Hospital Association—March 31-April 4; Cleveland (Hotel Cleveland)
Oklahoma Hospital Association—November 8-9; Oklahoma City (Skirvin Hotel)
Ontario Hospital Association—October 22-24; Toronto (Royal York Hotel)
Oregon Association of Hospitals—October 8-9; Salem (Hotel Senator)
Saskatchewan Hospital Association—October 24-26; Saskatoon (Bessborough Hotel)

(Continued on page 130)

Visual inspection



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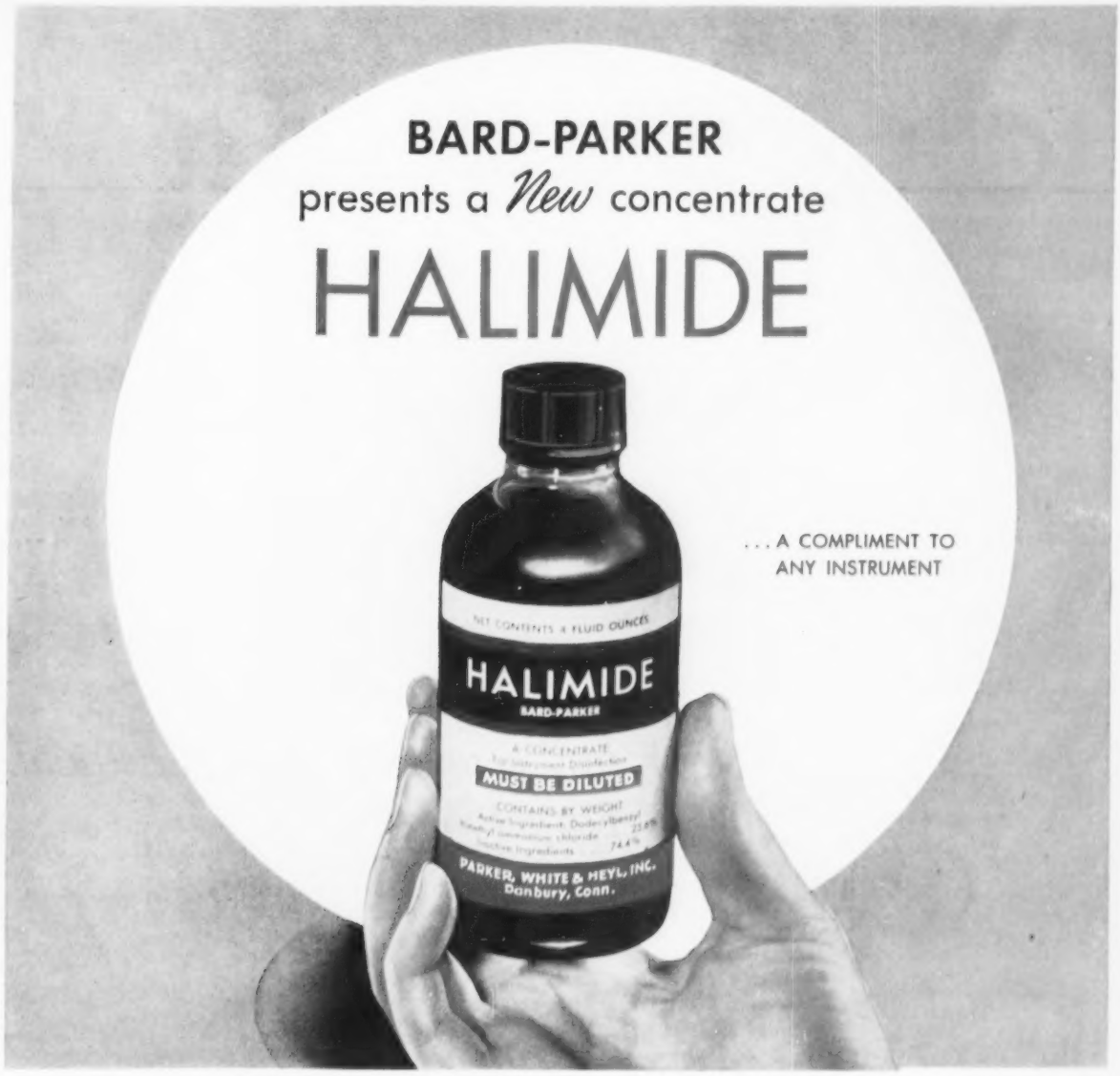

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1. Eichner, E.; Goler, G. G.; Sharzer, S., and Horowitz, B.: Obst. & Gynec. 6:511, 1955.

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2. Greenblatt, R. B., and Brown, N. H.: Am. J. Obst. & Gynec. 63:1361, 1952.

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4. Nulsen, R. O.; Carmon, W. B., and Hendrick, H. O.: Am. J. Obst. & Gynec. 65:1048, 1953.

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introducing the authors

A safe hospital is no accident

by William A. Hacker

William A. Hacker, administrator of McKeesport (Pa.) Hospital, has grown up with the hospital. He took his first job there as a clerk in the business office at the age of 16. At that time the hospital had 143 beds. Eleven years later, Mr. Hacker was appointed assistant superintendent of the hospital, and five years after that, superintendent. The present size of the hospital is 325 beds and an addition with 80 beds and 55 bassinets is planned.

MR. HACKER

Mr. Hacker is a trustee of the Hospital Association of Pennsylvania and chairman of their council on hospital auxiliaries; a member of the executive committee of the Hospital Council of Western Pennsylvania; a trustee of the Visiting Nurses Association of Allegheny County, and a member of the American College of Hospital Administrators.

Microfilming—solution or stopgap?

by Helen C. Chase

Helen C. Chase, associate biostatistician, New York State Department of Health, recently returned from a year's leave of absence spent at the University of California as a Public Health Service research fellow of the National Heart Institute. She expects to return next year as a university fellow for studies in maternal and child health.

Mrs. Chase received her B.A. from Hunter College, and her M.S. in biostatistics from Columbia University School of Public Health. She served for nine years with the New York State Department of Labor.

She was elected a fellow of the American Public Health Association in 1954 and chaired the statistics section, New York State Public Health Association, 1954-55.

MRS. CHASE

MR. TANNER

A hospital for children and their anxious parents

by Moir P. Tanner

Moir P. Tanner, director of Children's Hospital, Buffalo, was born in Cooperstown, N. Y., and graduated from Albany College of Pharmacy (affiliated with Union University), Schenectady, N. Y.

His first position in hospital administration was that of assistant superintendent of the Mary Imogene Bassett Hospital in Cooperstown. Two years later he became assistant superintendent of Buffalo (N. Y.) General Hospital where he remained until he assumed his present post in 1937.

Mr. Tanner has served as president of the Western New York Hospital Council, the Hospital Association of New York State and the Middle Atlantic Hospital Assembly. He is treasurer of the Hospital Association of New York State and regional secretary of the Buffalo Regional Council of the New York State Joint Hospital Survey and Planning Commission. He has been a regent of the American College of Hospital Administrators since 1951.

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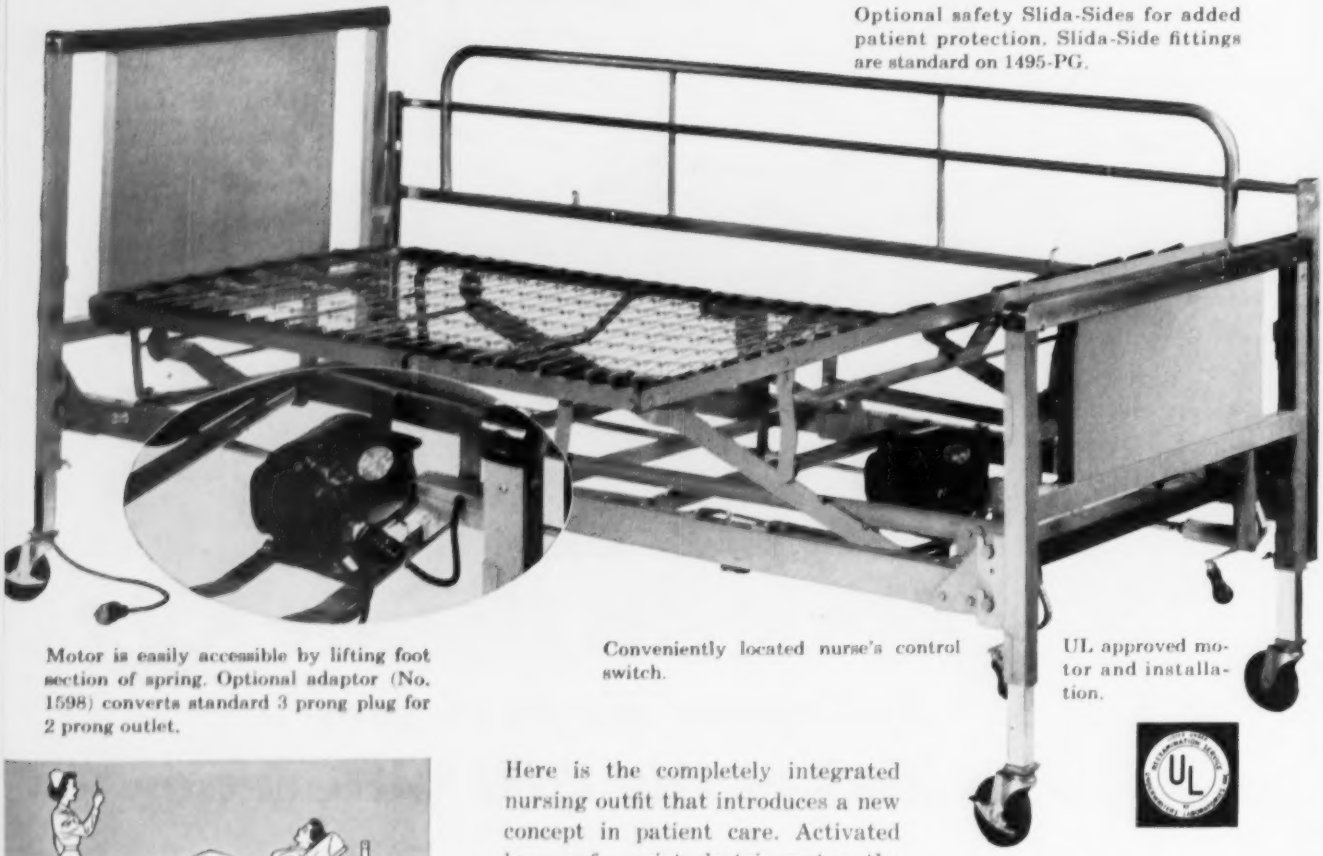
Optional safety Slida-Sides for added patient protection. Slida-Side fittings are standard on 1495-PG.

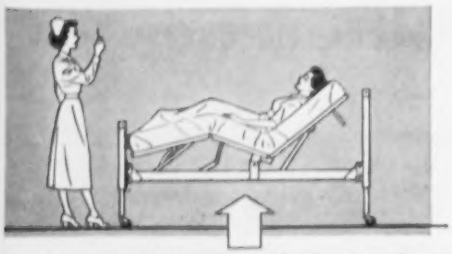


Motor is easily accessible by lifting foot section of spring. Optional adaptor (No. 1598) converts standard 3 prong plug for 2 prong outlet.

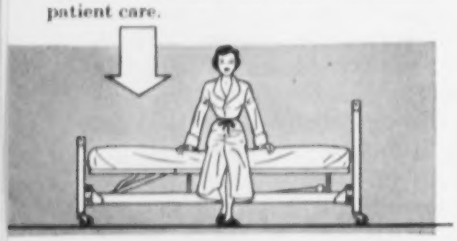
Conveniently located nurse's control switch.

UL approved motor and installation.

Here is the completely integrated nursing outfit that introduces a new concept in patient care. Activated by a safe, quiet electric motor, the ElectroMatic Bed raises and lowers its spring with the touch of a switch. And, like all Hard products, it's designed and built for long life service and economical maintenance.



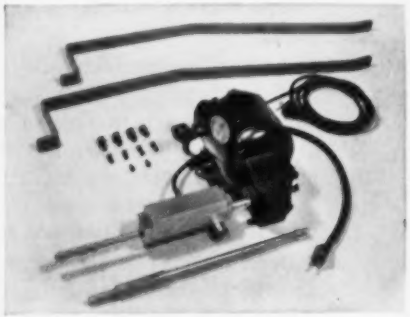
Saves nurse's time by freeing her for other duties while bed automatically adjusts to any desired height for most convenient patient care.



Patient can raise or lower bed himself, relieve helpless feeling with optional Patient's Control Switch No. 1599.

ALSO READY NOW!
HARD POWER PACK
UNIT 1595

To Convert Present Single Crank Multi-Hite Beds to ElectroMatic Action. Unit includes motor, relay switches, hanger brackets and special axle pieces for easy change-over.



HARD'S ElectroMatic BED and POWER PACK UNIT ARE APPROVED by UNDERWRITER'S LABORATORY for use with oxygen administering equipment of the nasal, mask type and 1/2 bed length oxygen tents.

Write for catalog pages on the ElectroMatic Bed and Power Pack Un

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BUFFALO 7, N. Y. FOUNDED 1876

. . . MAKERS OF LIFE LONG HOSPITAL AND INSTITUTIONAL FURNITURE AND EQUIPMENT

COURTS ACT IN CASES INVOLVING HOSPITALS—Three cases of importance in the hospital field have recently been ruled upon by courts in New York State, Ontario, Canada, and Oregon.

• The Court of Appeals, New York's highest court, has ruled that a hospital is liable for the negligent acts of its nonprofessional employees, even though the acts performed were medical in nature.

A lower appellate court had found the hospital not liable for the negligence of a laboratory technician in mistakenly reporting a blood type, with a resultant transfusion reaction.

In its unanimous opinion, the Court of Appeals brought up, but said it did not have to decide, the question of whether hospitals should be liable for acts performed by professionals (physicians and nurses) who "are salaried members of the hospital's personnel rather than outside professionals called in to minister to patients . . ."

Pointing out that hospitals ". . . sell services which are 'medical' in nature and though furnished on physicians' orders are performed wholly by and under the control of the hospitals' salaried staffs" the court asked "what reason compels us to say that of all employees working in their employers' businesses (including charitable, educational, religious and governmental enterprises) the only ones for whom the employers can escape liability are the employees of hospitals?"

• A ruling has been handed down by the Ontario Supreme Court that a public hospital's governing board is justified in requiring an audit of the books of members of its medical staff in order to eliminate "fee splitting."

Three practitioners on the Victoria Hospital, London, Ontario, medical staff had sought to nullify a hospital bylaw (the Columbus Plan) by having the bylaw declared outside the jurisdiction of the board.

During the course of the trial, the hospital declared that fee splitting had become a problem to the hospital and the board had to deal with it.

Under the existing municipal ordinances affecting hospitals, the action of the board was termed "positive," "regulatory," and "not prohibitive," by the court. In sustaining the board's viewpoint the court said the bylaw and the stated penalties for its infraction were reasonable.

• Oregon's Supreme Court held, in a recent case, that juries hearing cases in which hospitals are defendants should determine if the hospitals are charitable, nonprofit facilities, if their claims to be such are challenged by the plaintiffs.

"In effect the court holds that the mere fact that a hospital is organized under Oregon statutes that are intended to create charitable, nonprofit corporations is not necessarily controlling," commented James G. Swindells, Oregon Association of Hospitals attorney.

The state Supreme Court originally ruled in favor of the defendant (the hospital), but reversed its decision and finally said that a jury may hear evidence on a hospital's charitable status so as to determine the hospital's immunity from judgments for damages due to neglect by employees.

The court's decision means, Mr. Swindells said, that though Oregon's immunity law is not affected, ". . . if a hospital states that it is charitable and if the plaintiff denies that it is, then the hospital has the burden of proof in asserting such a defense . . . The acts and deeds and activities of the corporation will be examined to determine whether in truth and in fact it is charitable."

WASHINGTON HOSPITALS CHANGE PATIENT RATE SYSTEM—By instituting an all-inclusive daily rate for care of welfare patients in community hospitals, hospitals "will emphasize clearly the difference between what it costs the hospital to care for a welfare patient and what the hospital is receiving from the state," the Washington State Hospital Association has reported.

The new system went into effect last month; a fee schedule for various services rendered by the hospital had been used.

Presently, the Association said, community hospitals in the state of Washington, as a group, are being reimbursed about 80 per cent of what it actually costs them to care for welfare patients. The daily rate method will not change this percentage immediately, the Association said, but eventually it is hoped to lead to full reimburseable cost from the state.

PRIVATE MEDICAL SCHOOLS GET FORD GRANTS—The Ford Foundation has announced grants totaling $21.75 million to strengthen instruction in the 44 privately-supported medical schools now operating in the

Worth Quoting

". . . As pushbuttons take over the job of producing more of our material necessities . . . more young people will be leaving the production of goods to take up the professions of medicine, teaching, social work, and so on . . . It seems to me that more of our national income will need to be channeled into improving public services of all sorts. This will call for serious reappraisal of many things, including the low salaries we now pay to many professional people. High cost training and low level pay will not attract the young people we need now for public service—and will need still more in the years to come . . ."
—Herold C. Hunt, *undersecretary of the Department of Health, Education, and Welfare, at commencement exercises, New Jersey State Teachers College, Trenton, June 16, 1956.*

United States. Each of 43 four-year schools has been granted $500,000 and the two-year medical school at Dartmouth College, Hanover, N.H., has been granted $250,000.

The grants were authorized by the foundation's board of trustees upon the recommendations of a special advisory committee set up by the foundation to develop plans for distributing $90 million which the foundation appropriated last December to aid the instructional programs of private medical schools.

Recipient institutions are to hold the grants as invested endowments for at least 10 years. Income from the endowment may be expended by the school for instructional purposes, but not for construction or research needs. After 10 years the schools may use the principal sum as well as the endowment income.

CHICAGO HOSPITALS BATTLE POLIO—More than 387,000 free inoculations of Salk polio vaccine were given by Chicago area hospitals during the recent emergency there, the Chicago Hospital Council reported.

Although the program of giving first shots in hospitals was terminated Aug. 31, the Chicago Medical Society asked that hospitals continue to give second shots during September. The council believes the final count may exceed 425,000 shots.

At the height of the emergency (more than 1,000 cases were reported in the city) a shortage of beds for small children developed, the Cook County chapter of the National Foundation for Infantile Paralysis reported.

There was also a shortage in the number of available physical therapists. Vacationing therapists from other sections of the country were recruited and refresher courses for retired therapists were instituted.

A program of handling as many polio victims as possible on an outpatient basis has proven successful, the NFIP chapter said. To some extent this helped alleviate the bed and therapist shortages.

REPORT FROM WASHINGTON—Methods of adapting hospital facilities and services to the varying needs of patients are to be studied by members of the Advisory Committee on Hospital Facilities and Services, newly appointed by Department of Health, Education, and Welfare Secretary Marion B. Folsom.

Dr. Russell A. Nelson, director of the Johns Hopkins Hospital, Baltimore, was appointed committee chairman.

Secretary Folsom also appointed 12 members to the National Advisory Council on Health Research Facilities, a group established in the law authorizing $90 million in matching federal funds for construction of medical research facilities. (Details p. 109)

THREE EPILEPSY CLINICS OPEN IN NEW YORK CITY—Three new publicly supported anticonvulsive clinics were recently added to New York City's facilities for the treatment and care of those suffering from epilepsy, the United Epilepsy Association has reported.

The centers are located at the Columbia-Presbyterian Medical Center, Mount Sinai Hospital, and Saint Vincent's Hospital.

City and state departments of health allocated $105,000 to initiate the program.

There are substitutes for the mercury-type sphygmomanometer which undeniably have certain superficial advantages. But there is no substitute for unfailing accuracy, which *only* the true mercury-gravity instrument can assure.

The mercury displacement principle in bloodpressure measurement excludes the possibility of functional error in the instrument itself. It does not depend on the elasticity of metal, which varies, or on moving parts, which wear. Its action is governed solely by gravity – the most constant and unequivocal force known. As such, it provides the standard against which other types of manometers must be calibrated and checked when their accuracy is in doubt.

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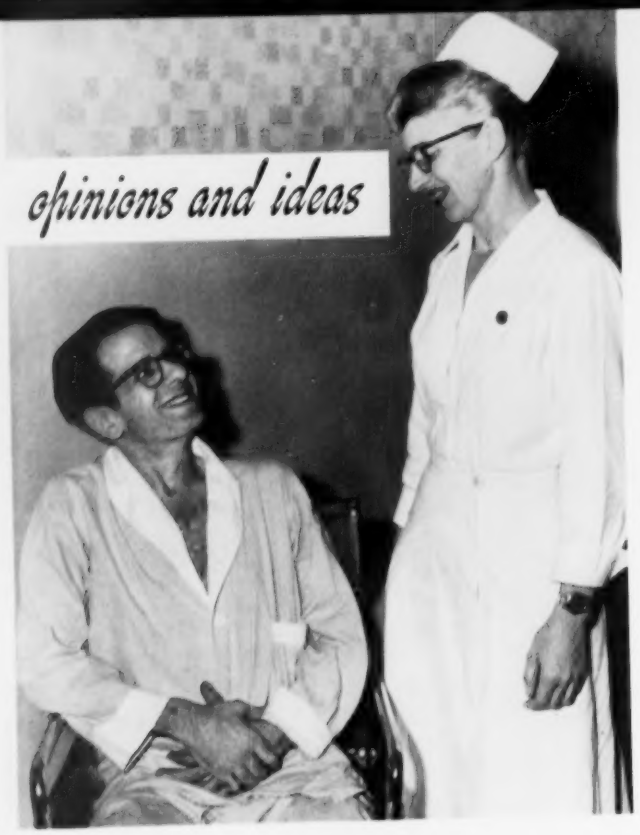


opinions and ideas

two approaches to better patient relations

Increasing recognition of the benefits for both patient and hospital from a well defined and energetic patient relations program is being manifested in hospitals of every size. Hospitals that have instituted such programs find that regular visits to patients help tremendously in building good will and stopping criticisms before they start. A patient relations program has the collateral advantage of bringing to light routinely any flaws in administrative, nursing or service methods.

The achievements of the programs in operation at Mount Sinai Hospital, Chicago, and Touro Infirmary, New Orleans, are similar. At both hospitals, a full-time staff member has become an important link between hospital management and the patient. The approaches used, however, are quite different. At Mount Sinai, patient relations are in the charge of a member of the nursing staff, while at Touro Infirmary an administrative assistant carries out the program.

At Mount Sinai Hospital, 373 beds, the addition to the staff of Miss Grace Peterson, R.N., as assistant director of nursing for patient relationships has made available to patients a trained person who, with no other responsibilities, devotes her entire time to visiting and welcoming new patients and helping to orient them to their hospital surroundings.

Through the service, patients receive extra attention that builds assurance that the hospital has a real interest in their welfare, according to Dr. Stephen Manheimer, hospital director, who makes rounds once a week with Miss Peterson.

Visits to patients have always been made at Mount Sinai, but formerly were made by the administrator, the director of nursing, or head nurse. Visits frequently were cut short by a page, a telephone call, or an urgent appointment.

Now, with many more patients in the hospital, more complex things to be done for them, and not enough personnel to do them, the patient relationships nurse performs the vital function of interpreting hospital services for patients, offering sympathetic counsel, or listening to problems or complaints.

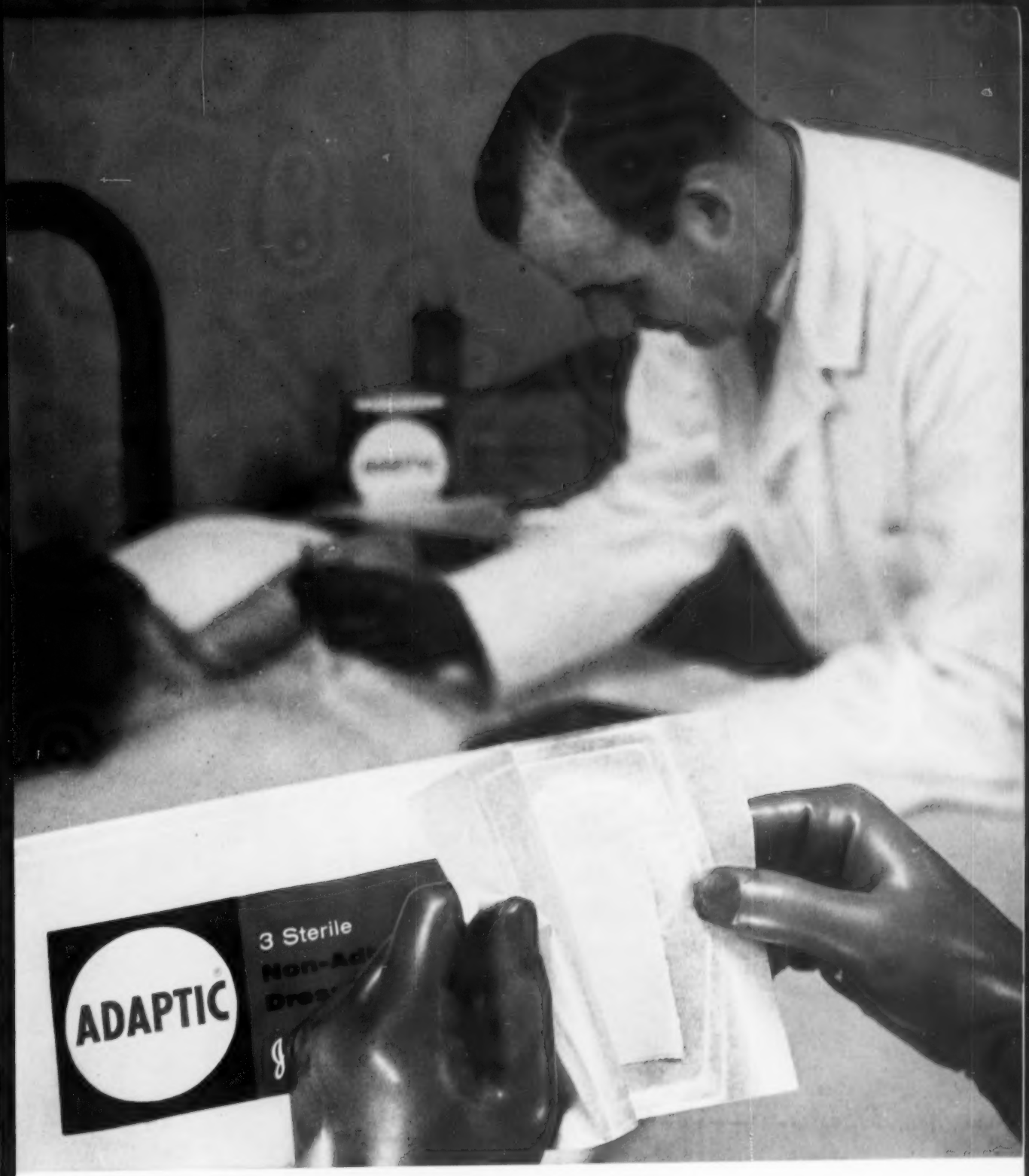
Interviews with patients are kept as informal as possible. The patient relations worker begins by introducing herself and stating her position on the staff. She inquires about the patient's health and progress, and encourages him to discuss any problems he may have. She volunteers to aid him in any way she can.

Occasionally, if a patient seems disturbed but has difficulty expressing himself, Miss Peterson employs "reflective therapy." By repeating the stated thoughts of the patient, she encourages him to elaborate on what he has said. The interview may be from 15 minutes to three quarters of an hour long. If the patient is very ill, the interviewer does not remain with him but comes back when he improves.

At Mount Sinai Hospital, the assistant director of nursing for patient relationships is not a part of the so-called line of command. She is off at the side, thus feeling none of the pressures and tensions experienced in connection with their duties by other members of the nursing staff. With visiting patients her sole responsibility, the patient relationships nurse can devote all her time to reassuring patients and clarifying hospital procedures for them.

Dr. Manheimer reports that in the short time since the patient relationships nurse was added to the staff there has been definite evidence of improved service to patients, higher patient morale, and greater understanding of hospital routines.

In the 457-bed Touro Infirmary it was impossible for the administrator to visit each patient, yet Dr. John C. Mackenzie, director, believed a close rapport between the administration and the patient and his family was highly desirable. This gap in the administrative or-



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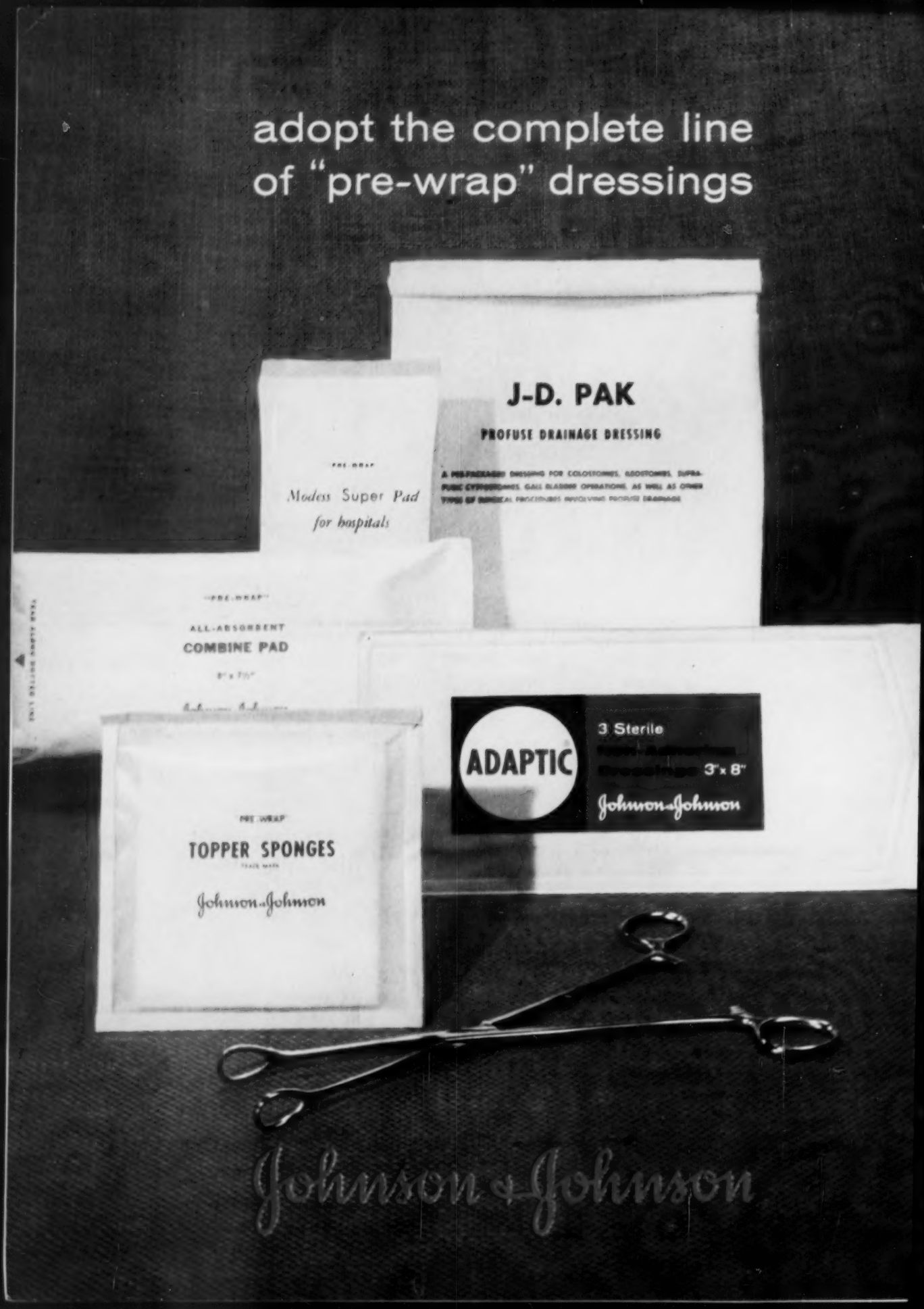
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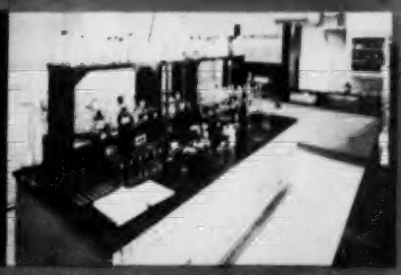

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ganization was closed with the appointment of an administrative assistant in charge of patient relations.

In creating the position, it was recognized that great care would have to be given to selecting the proper person for the job. A charming personality combined with a good sense of timing and tact headed the list of qualities considered essential. It was agreed that the person should be a mature woman who knew the hospital and the community well.

The person chosen for the position had been on the staff of Touro Infirmary for more than 20 years. She had a thorough knowledge of the hospital's procedures and had wide acquaintance among members of the community. Familiarity with the likes and dislikes of incoming patients has enabled her to be of greater service to patients and hospital alike.

Working with the Touro public relations department, the patient relations officer finds innumerable opportunities for public education in the complexities of hospital activity and economics.

As a representative of the director's office, the patient relations officer visits each patient as soon as possible after admission. She inquires whether the patient likes the food, if the room and service are satisfactory, and so on. The patient's name, location, and comments are included in a report submitted to the director. The report also includes notations of any services performed for the patient. If there are complaints, the patient relations officer investigates and takes action on the minor ones and refers others to the director or the public relations office.

The patient relations officer assists patients in any way possible. For example, she makes travel reservations, tries to locate lost items, or makes telephone calls.

As at Mount Sinai Hospital, the Touro patient relations officer carries no direct supervisory authority or responsibility. Because her work brings her in contact with nearly all departments, however, she has been able to gain the respect and cooperation of all personnel directly involved with patient care.

Touro Infirmary officials believe the program is a valuable part of the hospital's public relations work and that the patient relations officer is an important member of the administrative team.

Gift box for patients

On admission to Burlington (Iowa) Hospital, every patient receives a gift box containing supplies that can be used while he is in the hospital. The box itself measures 7¾ in. by 5¾ in. by 2 in., and is made of cardboard covered with an attractive linen appearing paper. On the cover are printed a picture of the hospital and the message, "Presented to you with the compliments of Burlington Hospital—with the desire that your hospital stay might be more enjoyable."

The gift box contains the following items, given here with the cost of each to the hospital:

1 bottle baby lotion	$.06
1 tube tooth paste	.05
1 tooth brush	.0675
1 cake hand soap	.0355
1 comb	.04
1 orange stick	.0066
1 pkg. mouth wipes	.0462
1 drinking straw	.0047
Bedside Manner, a folder published by National Safety Council	-
The box itself costs	.072
Total cost	$.3825

The articles included in the box are purchased by the hospital from hospital suppliers that give the best quotation in quantity prices. The hospital purchases the items in quantities that will equal one year's supply. The cake of hand soap included in the box has a special wrapper that gives the hospital's name and slogan. A patient's handbook, now being drawn up by the hospital, will be added to the box when it is completed.

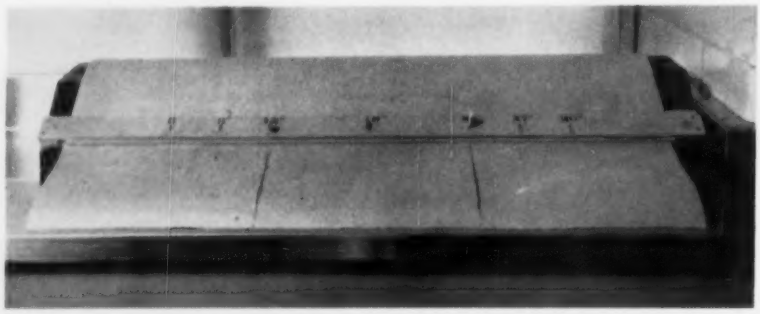
The cardboard box is made and printed for the hospital by a local box manufacturer. The patient is not charged for the gift box. The hospital believes the expense of the box is well justified by its public relations value. For a dollar, Burlington Hospital will send samples of the gift box to hospitals interested in adopting the idea. ■

Homemade paper cutter

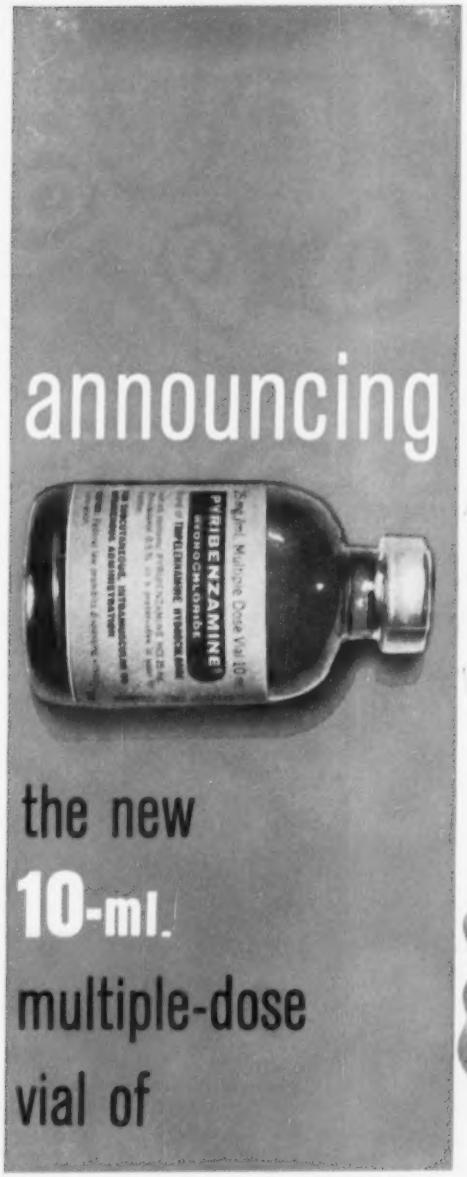
Problem: The central service department of Veterans Administration Hospital at New Orleans needed paper of varying widths for wrapping purposes, but did not want to allot money and space for keeping separate rolls on hand of widths most commonly used. Cutting desired widths from the standard 36-inch roll was cumbersome and time consuming.

Solution: A 36-inch paper stand was equipped, near its base, with a cutting device consisting of two narrow strips of wood which contain between them a sharpened blade. The upper piece of wood is notched and marked into varied desired widths, depending upon the use of the paper to be cut. The free end of the paper is placed between the wooden strips and underneath the blade.

If full width paper is desired it can be cut by pulling down the length needed and then up and across the blade as in any standard paper cutter. When specified sizes are needed, the notches in the upper wood strip can be fitted with discarded surgical knife blades made safe for use by wrapping the free end with any type of adherent tape. Paper is then pulled down over the blades and up across the long blade, thereby cutting several pieces simultaneously.



CUTTER THAT cuts paper of several widths from a single roll is set here for three 12-inch sheets.



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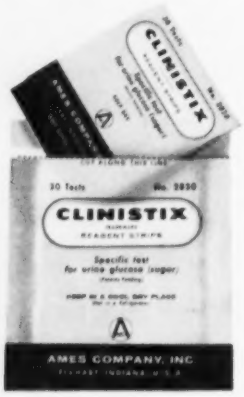

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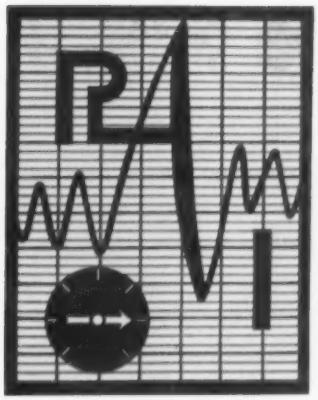

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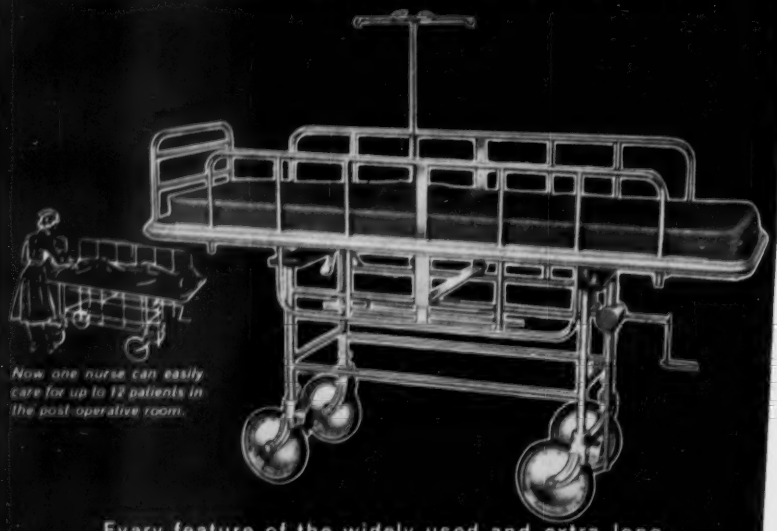

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Architects: Isadore Rosenfield, New York; York and Sawyer, New York; Sherlock, Smith and Adams, Montgomery, Alabama

In selecting casework to meet the complex needs of 10 new Mineworkers Memorial Hospitals, the final choice was casework by St. Charles *throughout all 10!* Proof once again that St. Charles' reputation for quality, dependability and economy meets the test of exacting requirements.

St. Charles' long experience and highly skilled personnel, backed by the nation's newest, most modern casework construction facilities, stand ready to help you on any problem of casework and design. Your inquiries receive prompt attention.

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Shown above are pictures taken at the Beckley Memorial Hospital, one of 10 recently constructed by Miners Memorial Hospital Association under United Mine Workers of America Welfare and Retirement Fund Auspices.

Project Locations

Beckley Memorial Hospital
Beckley, West Virginia

Man Memorial Hospital
Man, West Virginia

Memorial Medical Center
Williamson, West Virginia

Pikeville Memorial Hospital
Pikeville, Kentucky

McDowell Memorial Hospital
McDowell, Kentucky

Hazard Memorial Hospital
Hazard, Kentucky

Whitesburg Memorial Hospital
Whitesburg, Kentucky

Wise Memorial Hospital
Wise, Virginia

Harlan Memorial Hospital
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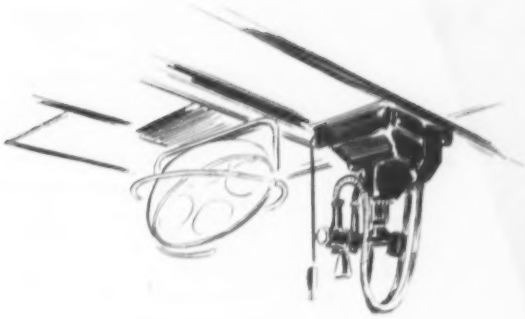

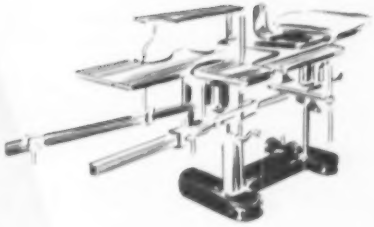

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Members outside U. S.

I am most interested in your Association and would like to know whether you accept members outside the United States. If this is possible, I would very much like to join your ranks.

Individuals outside the United States are accepted as personal members. However, personal membership in the American Hospital Association is limited to individuals associated with member hospitals, related organizations in the hospital field, or governmental or nonprofit agencies concerned with hospitals.

As an institutional member of the Association, your office would receive the full range of Association services and publications.

—HOWARD F. COOK

Hospital housekeeping program

We would greatly appreciate information on organizing a housekeeping training program for our employees.

There are several publications available which should be very helpful in organizing a housekeeping training program. Three publications are available from the American Hospital Association:

Manual on Hospital Housekeeping—$1.50;

Manual on Hospital Maintenance—$1.50;

Training Hospital Employees—$5.50. This book includes the basic steps of a training program as well as detailed material on housekeeping and several other hospital departments.

Administrative Housekeeping, by Alta M. LaBelle and Jane Barton, published by G. Putnam's Sons, 210 Madison, New York 16, is also an excellent reference book on hospital housekeeping.

—JACK D. DILLMAN

Preparing for disaster

We are planning a new hospital and are anxious to institute a disaster program that will serve our community in case of any calamity.

What facilities, equipment and supplies are recommended for an adequate program? Is there any government agency which supplies these hospital needs?

There are a number of things to be considered when preparing a hospital disaster program which bear on the actual design and construction of the hospital buildings. One very important consideration in this respect is planning for standby or emergency power and

The answers to these questions should not be construed as being legal advice. Hospitals with legal problems are advised to consult their own attorneys.

Heavy-Duty—EXPLOSION-PROOF HERB-MUELLER Ether-Vacuum Apparatus

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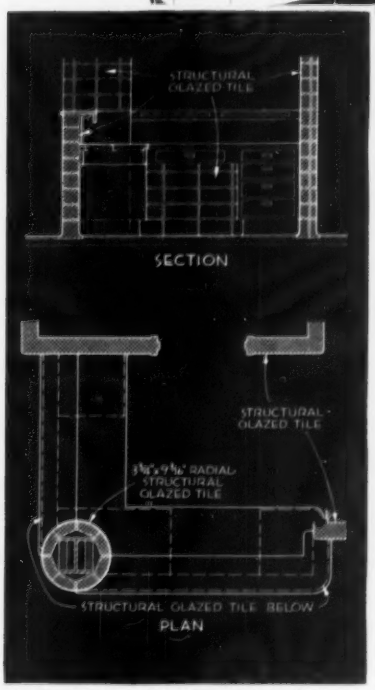

Nursing Station, Ambulance Lobby, Elmhurst General Hospital, New York City Department of Public Works, for the Department of Hospitals.

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in STARK *structural glazed facing tile*

Here's an interesting use of a well-known architectural treatment for hospital buildings — trouble-free, maintenance-saving walls of Stark Structural Glazed Facing Tile.

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STRUCTURAL

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other utilities. Often the same disaster that injures people will damage electric lines, water supply, and otherwise disrupt many services essential to the continued operation of the hospital.

Provision for emergency electrical power may require separate wiring circuits throughout the hospital, or special switchover provisions at the switchboard.

Provision for alternate sources of water should also be considered in the event floods or other disasters should contaminate the normal source of supply. Some hospitals have drilled wells to provide an emergency source of water. Further assistance on this question can be obtained from your local public health organization.

With respect to receiving and caring for large numbers of casualties from a disaster, not too much can be provided for in the structural planning of the hospital. However, an aid to effective disaster operations is the free flow of casualties through the sorting and treatment facilities within the hospital. Consideration should be given to adequate corridor and treatment space in the emergency section of the hospital.

Separate entrance and exit roads to and from the emergency entrance of the hospital help materially in facilitating ambulance traffic.

Considerable use was made of helicopter transportation in last year's floods in New England and California. They were used to transport injured people to the hospitals and to carry supplies to and from hospitals. Mr. Charles V. Wynne, administrator of the Waterbury (Conn.) Hospital, has said that every hospital should have an ample parking lot which could be used as a helicopter landing area in emergencies.

Extra medical and surgical supplies should be kept at the hospital for emergencies. The opinion of many administrators who have experienced disasters is that the inventory of medical and surgical supplies should be increased to about a 10- to 14-day supply in excess of that needed for normal hospital use. This should provide a backlog that can be used in a disaster emergency at least until additional supplies can be obtained from outside sources. Consideration may also be given to providing additional storeroom space to permit such stockpiling of supplies.

Regarding assistance from a government agency, I would suggest your local civil defense organization. The Federal Civil Defense Administration has a "contributions program" whereby matching funds can be made available on a 50-50 basis to finance approved projects of state and local civil defense organizations. With FCDA's increased emphasis on natural disaster activities, I believe this assistance may be given for the purchase of emergency power equipment, medical-surgical supplies and other items directly related to disaster preparations.

Additional information on disaster planning may be found in two recent publications of, and available from, the American Hospital Association: *Principles of Disaster Planning for Hospitals*, 75 cents per copy; *Readings in Disaster Planning for Hospitals*, $1.50 per copy.—JOHN N. HATFIELD II

THE BRAIN that keeps blood temperatures constant at all times in the Jewett Cylindrical Blood Bank

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Should the thermostatic control fail, the second control automatically operates the refrigerator within safe limits until the thermostat is corrected.

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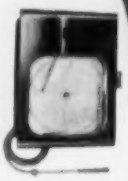
This standard equipment feature sounds an alarm should the blood temperatures fall or rise dangerously.

RECORDING THERMOMETER

Available as an added feature; gives you a continuous, accurate, permanent record of stored blood temperatures.



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Architects and Engineers: Smith, Hinchman & Grylls, Inc.

Contractor: J. A. Utley Co.

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This window meets or exceeds all quality industry specifications for aluminum windows
THE Adams & Westlake COMPANY
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This handsome building at 441 East Jefferson Street, Detroit, is a typical example of wise remodeling with Adlake windows.

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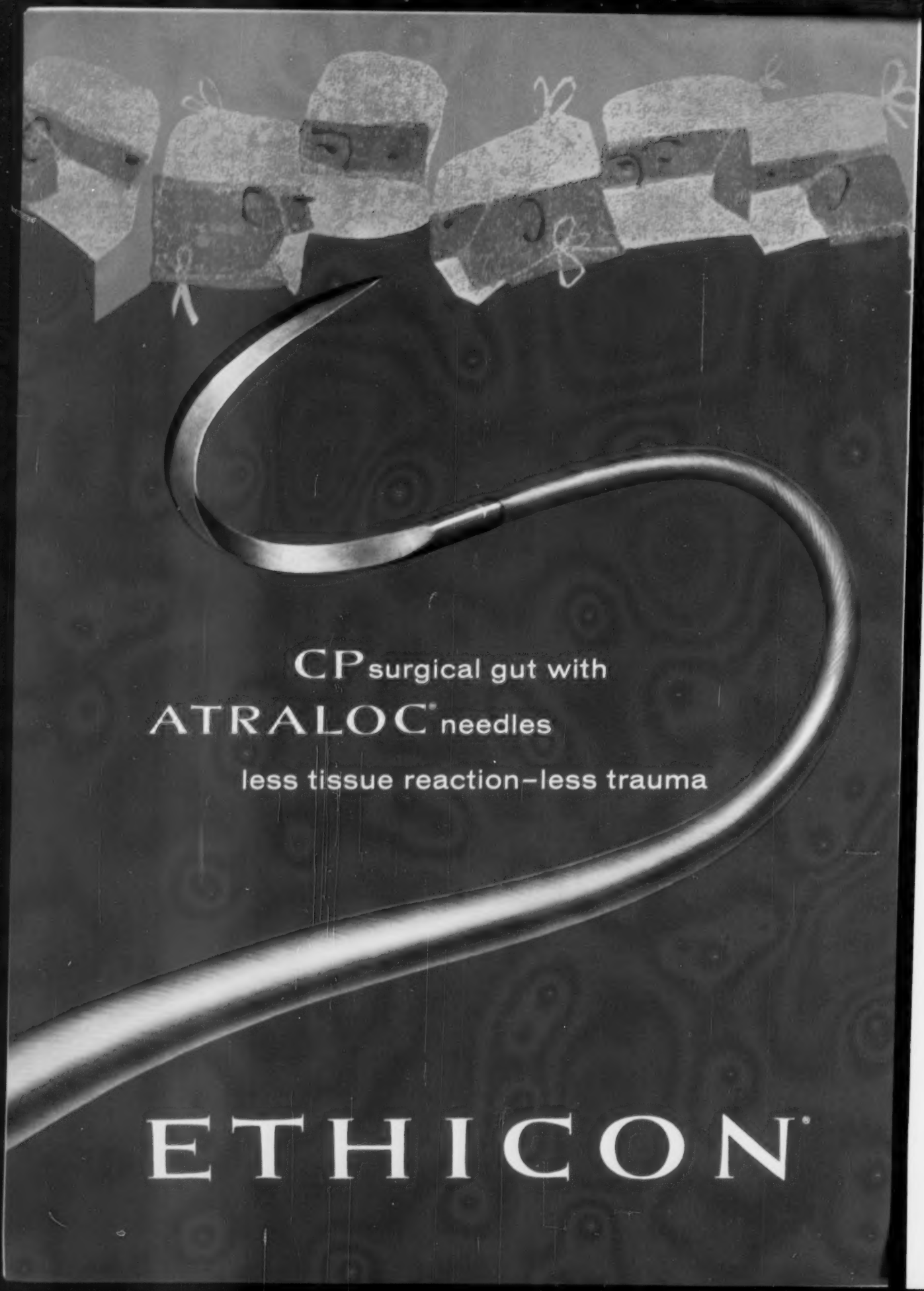
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New hospital addition has

ROOM-BY-ROOM TEMPERATURE CONTROL

with Iron Fireman SelecTemp Heating

Blanchard County Hospital, Findlay, Ohio, will use about 100 SelecTemp room heating units as part of their expansion and modernization program. SelecTemp units are recessed in walls, use no floor space. Each room unit has built-in non-electric thermostat. Architect: Wilbur Watson Associates, Cleveland.

Compact steam units with non-electric fans and thermostats bring a degree of comfort, economy and safety never known before in hospital heating

SelecTemp heating makes it possible to have the temperature desired in any room at any time.

The value of room-by-room temperature control need hardly be pointed out to anyone familiar with hospital routine. The temperature of each bedroom can be regulated to fit the patient's needs, day and night. Each special room—nursery, surgery, recovery rooms—can be held at the temperature desired. Heat is steady and very uniform.

A point of particular interest to hospitals is that SelecTemp room units are completely non-electric; therefore safe in operating rooms and laboratories.

Economically Installed and Operated. SelecTemp is engineered for economical installation in either old or new construction, as can be readily understood by checking the "SelecTemp Highlights" column at right. Experience has shown that SelecTemp costs no more than many systems having no zone control of temperature.

Operating costs are low because no heat is wasted through open windows in overheated rooms. Heat can be turned down in unoccupied rooms, with further fuel saving.

For Cooling. Iron Fireman individual unit cooling, with SelecTemp heating, makes the perfect all-year combination for patient and employee comfort and economical operation.

For free literature describing the SelecTemp heating system, please send the coupon.

SELECTEMP HIGHLIGHTS

THERMOSTAT IN EVERY ROOM. Temperatures can be varied in every room to fit the "activity plan" and personal preference of the occupants.

MODULATED HEAT. Air circulation is continuous. Both temperature and volume of air are automatically modulated, as required to offset heat loss from room.

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BOILER LOCATION. Boiler can be placed in any desired location, with proper distribution of heat to every room.

LOW POWER COST. No electricity required to operate circulating fans. Non-electric thermostats.

LOW INITIAL COST. Easily installed in either new or old construction. Small soft copper tubing carries steam from mains to individual room heater units. Substantial savings in installation costs.

LOW FUEL COST. Temperature easily reduced in unused rooms. Overheating is eliminated. Fuels: Oil, gas or coal. Ideal for use with Central District steam.

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EVERY ROOM A ZONE

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☐ Please send free literature describing SelecTemp heating.
☐ Please arrange for trial demonstration, in our own office, of SelecTemp unit in actual operation.

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Over the Goal by $88,000

ELK COUNTY
GENERAL HOSPITAL
Ridgway, Pa.
Administrator: F. W. Gradie

Goal: $652,000

Pledged: $740,000

Architect's rendering of the 4-story hospital to be built in Ridgway, Pa. Architect: Thomas K. Hendryx, A.I.A., Bradford, Pa.

Four days ahead of schedule, hundreds of volunteers led by enthusiastic community leaders reported pledges of $740,000 in a hospital service area of only 14,000 population. Individual gifts far exceeded expectations. Employees of the 17 companies in the area pledged an average of $56.

To produce the spirit that results in this kind of giving requires more than a knowledge of campaign techniques. Volunteers and professionals alike must be truly interested in the needs of the community and must be able to transmit their interest to others in terms of enthusiasm.

Quentin Graham, President of the Elk County General Board of Trustees, says of the Ketchum staff: "*They worked tirelessly, and what is more important, they inspired all of the committees and workers, imparting to them much of their own enthusiasm. Those of us close to the campaign are sure it wouldn't have been possible without the inspired leadership furnished by the Ketchum representatives.*"

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1. Freeman, B. S.; and Young, T. K., Jr.: *Arch. Surg.*, 61:1145, Dec., 1950. 2. Shay, D. E.: *Oral Surg., Oral Med., & Oral Path.*, 4:355, Mar., 1951. 3. Canzonetti, A. J.; and Dalley, M. M.: *Ann. Surg.*, 135:228, Feb., 1952. 4. Bowers, R. F., in discussion of Price, P. B.: *Ann. Surg.*, 134:476, Sept., 1951.

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Hospitals throughout the nation have discovered the effectiveness, economy and complete dependability of Executone for *all* services. Executone's Audio-Visual Nurse Call System alone is now serving over 12,000 hospital beds. Find out—*without any obligation*—how Executone can work for you as it does for Mt. Sinai and the entire hospital field. Write to Dept. 41 for further information: Executone, Inc., 415 Lexington Avenue, New York 17, N. Y. (In Canada—331 Bartlett Avenue, Toronto.)

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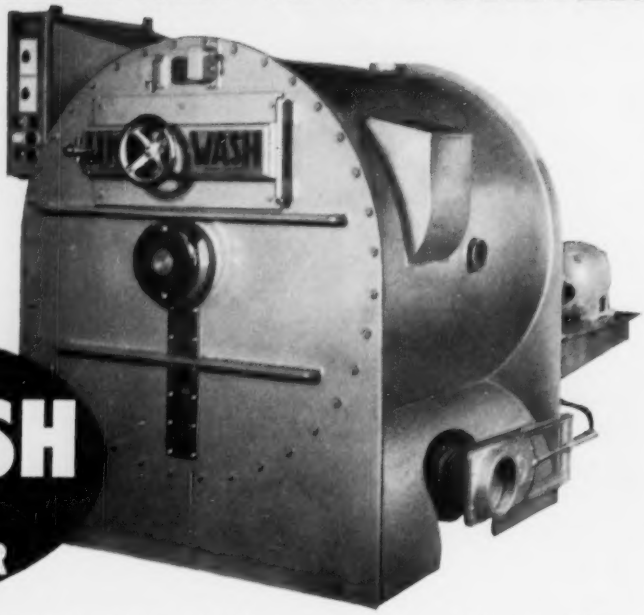

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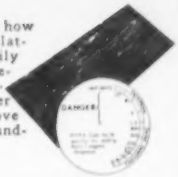
Hillyard Conductive Floor Cleaner is especially formulated for the cleaning of Conductive Floors as specified and described in the booklet, "Safe practices for Hospital Operating Rooms" NFPA No. 56 dated May 1954–Conductive Floors complying with these requirements must have a resistance of 25,000 to 1,000,000 Ohms as measured between two electrodes placed 3 feet apart at any points on the floor.

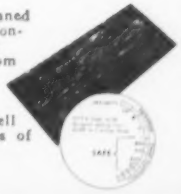
All field tests were made with strict observance to these requirements. Safe readings were maintained by simple, proper treatment and maintenance procedures using Hillyard Conductive Floor Cleaner exclusively.

The panels to the right show the great variance in Ohmeter readings between conductive floors cleaned with ordinary soap type cleaners as contrasted with the same floors cleaned with Hillyard Conductive Floor Cleaner.

The panel shows how destructive insulating film can easily be built up to destroy conductivity with Ohmeter readings well above the accepted standards.



The panel—cleaned with Hillyard Conductive Floor Cleaner, free from any insulating film, delivers safe readings well within standards of safe practices.



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AN INSULATING FILM ON YOUR FLOOR DESTROYS CONDUCTIVITY

Any cleaning materials that will leave a soap scum or thin insulating film, will by frequent use soon cause complete insulating. With Hillyard Conductive Floor Cleaner there is NO harmful film left from this material to build onto the floor to retard or destroy conductivity.

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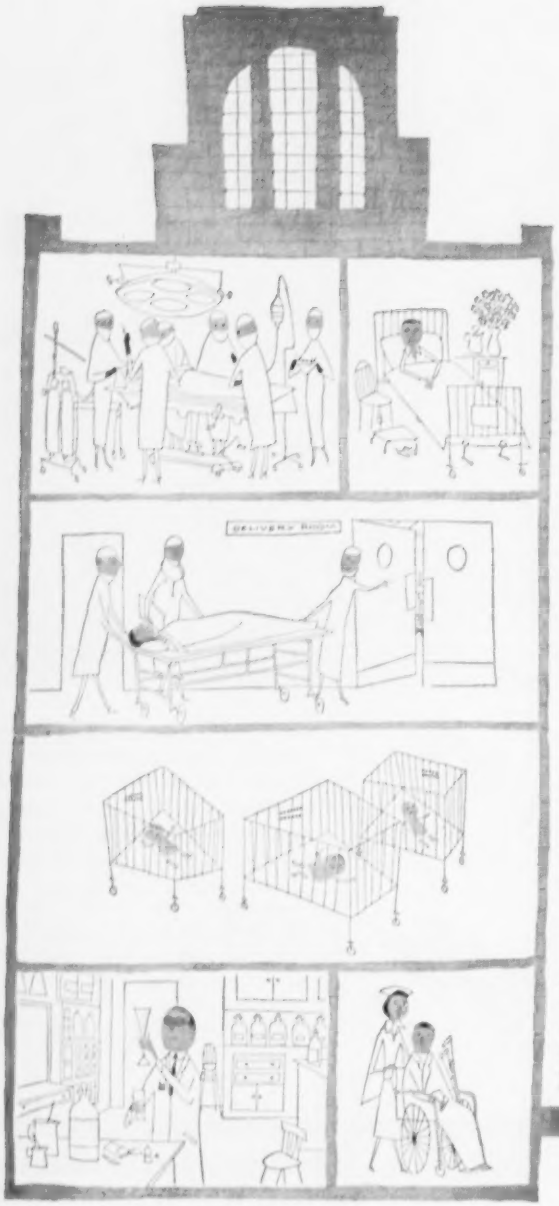

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HOSPITALS
JOURNAL OF THE AMERICAN HOSPITAL ASSOCIATION

editorial notes

—an Alamo for young Davy Crocketts

A hospital is not a place where people go to have fun. But a hospital—particularly a children's hospital—need not be a solemn place. Indeed, as Moir Tanner writes in his article beginning on page 51, "a children's hospital lobby on a Sunday afternoon may easily become an Alamo for young Davy Crocketts."

In planning a hospital for children, the first consideration naturally should go to the patients. But, as Administrator Tanner points out, "in designing a pediatric hospital parents deserve all the consideration the planners can give them."

When her child is sick, it is a rare mother who is not, to use Mr. Tanner's word, anxious. She wants to be near her child; frequently she wants to spend the night in the hospital. Her comfort, as well as that of her sick child, are provided for in the building program of the Children's Hospital, Buffalo, N. Y., described by Mr. Tanner in his article.

—concern with quality

The hospital accreditation program and its progenitor, the standardization program of the American College of Surgeons, constitute a voluntary effort by the health professions to establish basic qualitative standards for hospital care in the United States and Canada.

The primary reward has always been one of satisfaction—satisfaction that the hospital and its elements submitted to a more rigorous inspection than the law required and did so because of a desire to elevate voluntarily the quality of hospital care.

To be sure, there was, and is, a large measure of prestige in being able to display the certificate of the American College of Surgeons and, now, the certificate of the Joint Commission on Accreditation of Hospitals. And, from the beginnings, there were pressures (such as the accreditation requirement for internship and residency approval as well as community confidence) which impelled hospitals and their staffs to seek approval and to meet approval standards.

It must be recognized that the coercive elements in this voluntary approval program have increased of late. Some Blue Cross Plans will not contract with a nonaccredited hospital; grants from the National Foundation for Infantile Paralysis go only to accredited hospitals; approval of various training programs is withheld from nonaccredited hospitals.

The most recent development is to couple the voluntary accreditation program with the licensing powers of the state. One of the "Acts and Resolves" of the 1956 Massachusetts legislature provides for a medical audit of all hospitals by the state except those voluntary hospitals "fully accredited by the Joint Commission on Accreditation of Hospitals."

In Washington, the hospital licensure law, passed in 1955, calls for cooperation between the licensing agency and the Joint Commission. The rules and regulations now being drafted to implement the law propose that the state licensing agency would accept accreditation as evidence that the hospital satisfied the requirements in those areas (medical staff, etc.) with which the accreditation survey is concerned.

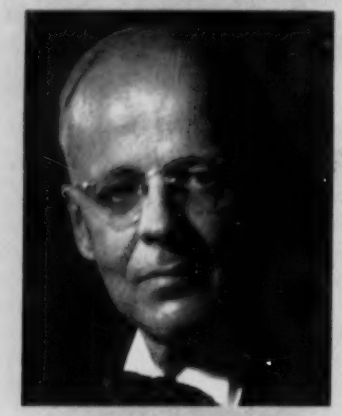
There is room for argument as to whether it is wise for a voluntary program, such as exemplified by the Joint Commission, to be written into what basically are expressions of the police power of the state. But these laws are on the books of Washington and Massachusetts. No philosophical argument is going to erase their language.

These laws and the decision of various agencies to deal only with accredited hospitals are recognition of a growing concern, by government and others, with the qualitative level of hospital care, and of the objective appraisal of this level by the Joint Commission.

It seems to us far more preferable that, for the sake of the patient, every hospital voluntarily meet the standards of quality they and their representatives voluntarily set rather than be forced to do so by government police power through licensing laws. As has been said over and over again, any hospital which really wishes to meet the standards of the Joint Commission can do so. No hospital should do less.

the hospital-specialist controversy:

the problem and possible roads to agreement as seen by



a radiologist . . . . . FREDERICK B. EXNER, M.D.

THE DAILY dealings between physicians and hospitals are generally polite and pleasant, and marked by the tolerant give and take that are necessary to successful cooperation; but this does not prove that all is sweetness and light in the area of physician-hospital relations. Close underneath, in all too many cases, are smoldering distrust, antagonism, resentment, and even hatred, which can and do break out in violent conflict especially when those medical

Frederick B. Exner, M.D., a radiologist, is president of the King County Medical Society, Seattle.

an attorney . . . . . ROBERT W. GRAHAM

HISTORICALLY, almost without exception, our courts have concluded that corporations cannot practice the learned professions. With respect to the practice of medicine, the prevailing authority is that it is unlawful for a corporation to engage in the practice of medicine. The weight of authority is predominant that the nonprofit corporation as well as the business corporation is unable to engage in the practice of medi-

Robert W. Graham is an attorney with the law firm of Bogle, Bogle & Gates, Seattle.

an administrator . . . . . RITZ E. HEERMAN

THERE IS NOT one point in these discussions on hospital-physician relationships that is not clarified by the joint statement of the American Hospital Association's House of Delegates and the American Medical Association's House of Delegates entitled, "A new statement on hospital-physician relationships." This statement was approved on June 3, 1953, by the American Medical Association, and on August 30, 1953, by the American Hospital Association. Its essence is summarized in Sections 3,

Ritz E. Heerman is general manager of the Lutheran Hospital Society of Southern California, Los Angeles.

where does the solution lie?

These articles are adapted from material presented in Seattle at the 1956 convention of the Association of Western Hospitals.

specialties which hospital people like to call "ancillary services" come under discussion.

By unspoken agreement and to minimize discord, such discussions have been avoided insofar as possible, with the result that the suppressed tensions and misunderstandings have grown ever greater. If a disastrous explosion is to be avoided, there must be a meeting of the minds which can come only from unemotional discussion.

Both sides have real or fancied grievances, and to pretend otherwise would get us nowhere. To achieve understanding each side must be free to state without rancor how things have appeared to it, and each must try to see how they appeared to the other. Perhaps then a new and mutually acceptable point of view can be achieved. At least it is worth a try.

There are encouraging signs, and recently a prominent hospital administrator wrote me that "as a professional man in a highly trained and intricate specialty, the specialist has rights which we in the hospital field overlook." But encouraging as such an admission may be, it seems to me that it misses the real point. The point is not that the specialist has rights that those in the hospital field overlook. It is that the patient has rights which the physician is under obligation to protect, and which hospital people have not even understood, much less respected.

It is in the nature of things that to be a "patient" and to enjoy the rights and protections of that status, a person must be under the care of a physician who is directly and personally responsible to him.[1]

(Continued on page 50)

[1]Exner, F. B., "Physician-Patient Relationship," *Northwest Medicine*, 54: 149-155, (Feb.) 1955.

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cine even though the officers of the nonprofit corporation and the employees performing the services are licensed physicians.

Justification of the prohibition against corporate practice of medicine has been expressed or predicated upon various grounds, all of which have been various ways of expressing an underlying concept:

There is a professional relationship between doctor and patient that is of necessity personal and perhaps indefinable, calling for undivided loyalty on the part of the professional man. The relationship places the obligation of service above economic incentive and permits the doctor to recognize no other duty than that owed the patient to give the best that is within his power. The relationship imposes a personal responsibility upon the physician for the results of his actions.

The premise that the professional man's loyalty must be unlimited is so well engrained within the minds and experience of our lawyers and judges that, in my judgment, courts will continue to conclude that the practice of medicine cannot be undertaken by corporations, charitable or otherwise.

It may well be that social experience can and will demonstrate that the welfare, health and best interests of the medical patient are best furthered by a system under which medical practice is in the hands of a corporate entity. It may well be that society will ultimately evaluate that the corporate practice of medicine by our charitable hospitals, or others for that matter, will be in the public interest.

Until that time, I think we must

(Continued on next page)

4, 5, and 6, as follows:

"(3) The medical profession and the hospitals recognize that certain special services, such as anesthesiology, pathology, radiology, and physical medicine are integral parts of the practice of medicine and of the services necessary for hospital patients. Physicians in these fields should have the professional status of other members of the medical staff. Chiefs in these specialties must assume also the administrative responsibilities and relationships customarily associated with such positions.

"(4) The right of an individual to develop the terms of his services on the basis of local conditions and needs is recognized, but such contractual arrangements should in all cases ensure

"(a) the policy of professional incentive for the physician, and

"(b) progressive development of the hospital departments involved, in order that increasingly improved services to patients may be rendered. Moreover, a physician shall not dispose of his professional attainments or services to any hospital, lay body, organization, group, or individual, by whatever name called, or however organized, under terms or conditions which permit exploitation of the patient, the hospital, or the physician.

"(5) The chief of a hospital department may have access to financial information regarding his department.

"(6) It is desirable that means should be provided at local, state and national levels for review of problems of individual hospital-physician relationship by organized medical and hospital groups."

Most of the difficulties involving hospital-physician relations stem from the fact that persons involved do not understand the agreement.

Hospital administrators some-

(Continued on next page)

ADMINISTRATOR

(Continued from preceding page)

times fail to recognize that the specialty physicians enumerated are practicing medicine.

The simplest way for hospitals to recognize that the specialty service is the practice of medicine is to have a contract with the specialist.

This contract should, of course, specify that the physician is an independent contractor practicing medicine and that the hospital does not dictate to him in any way how he is to practice medicine. He, however, must assume responsibility for selecting and keeping on the payroll certain technicians who, even though they are on the payroll of the hospital, are under his entire jurisdiction and he must be responsible for the work they are directed to do.

The contract should specify that the physician is to make up a fee schedule to be approved by the medical staff and the hospital and that all fees billed should be assigned to the hospital for collection.

Under the contract, any method of compensation—guaranteed minimum, commission on gross, or a commission on adjusted gross—can be satisfactory, providing the items enumerated above; namely, that the terms and conditions do not permit the exploitation of the patient, the hospital, or the physician.

CHARGE FOR FACILITIES

The attorney member of this symposium has suggested that the hospital should merely charge for facilities and have nothing to do with the payment of the specialist's consultation fees, and that his fees should be handled the same as the fees of the surgeon. This could easily be done in the hospitals.

If we go back into the history of the use of our surgery facilities, we could have started wrong by saying that the surgery space should be rented to the surgeon and the surgeon would collect from the patient and reimburse the hospital.

The radiologist in his presentation raised the question of whether the specialist could, under such an arrangement, properly assume responsibility for the technicians.

My opinion is that there would be no difference. In surgery, where the surgeon is in complete charge of the surgery while operating, he must assume the responsibility for the direction of nurses and other persons in the surgery. If the hospital adopted the proposal of charging for the use of x-ray and laboratory facilities and left it up to the medical staff to appoint consultants to interpret the work of the technicians, it would mean that the present monopoly of radiologists and pathologists would be over.

The hospitals could make this transition overnight, and if the present agitation by specialists continues, this will be the solution. However, in general, the experienced hospital administrator is not in favor of this change; he feels that it is better under the present contract arrangements to have one person responsible for each service, even though it may grant a monopoly to such specialists.

I am opposed to the theory advanced that the space should be rented to a radiologist or a pathologist on the grounds that such a plan may upset the present tax exemption of most nonprofit hospitals.

I am also opposed to it on the basis that such space can be rented in a hospital at the same price as the specialist would rent space in an office building. I have made a detailed analysis of the difference in the cost of constructing a highly specialized hospital building where 70 per cent of the space is for service and only 30 per cent for patients and the cost of constructing an office building where 85 to 90 per cent of the space is for the use of tenants.

From the difference in the cost of construction and maintenance, it has been determined that if a hospital was to consider renting space, it should charge approximately five times as much for the space as in an office building.

The fact that some physicians try to interpret the policy statement as entirely related to the dollar also leads to hospital-physician misunderstandings. If all parties would keep in mind the simple statement in Section 4 that no arrangement should exploit patient, hospital or physician, the dollar sign should be eliminated.

ASSIGNING OF FEES

Another theory, which certain specialists would like hospital administrators to adopt, is that such specialists cannot assign their fees to the hospital for collection. This theory is not based on legal determination or practical service to sick people. If all parties will be realistic, such assignment of the collection of fees promotes good public relations for the medical profession and the hospital, and prevents the exploitation of the patient.

Another controversial point in these relationships is: What are reimbursable costs to the hospital? When such a controversy exists without solution by conference, the one practical solution is to determine costs through an independent auditing concern. However, reimbursable costs to the hospital must be realistically approached by hospital administrators so that they will know their costs. A major factor in determining cost is space, which should be considered on a square foot basis insofar as capital costs, maintenance, repairs, utilities, and depreciation are concerned. The hospital administrator must also consider that all the other overhead of the hospital should be properly prorated to the specialty departments, including approximately 30 per cent of nursing time. This principle has been well documented in cost studies that show nurses on the floor spend a great deal of time writing orders, collecting specimens, getting patients ready for x-ray and laboratory procedures, and taking care of all the miscellaneous charting and various other items connected with specialty services needed by the patients. ■

ATTORNEY

(Continued from preceding page)

accept the proposition that it is not only unethical but illegal for a corporate entity to provide medical services for compensation.

WHAT ARE MEDICAL SERVICES?

I surmise that little support would be found among hospital

administrators for the proposition that the nonprofit corporation should be able to hire a surgeon, an obstetrician, or an internist and purvey their services for hire. But when we consider the relationships between the hospital and the so-called specialties—radiology, anesthesiology, pathology, and physical therapy—the unanimity of thinking vanishes.

It seems to me that the problems involving relationships between these specialties and the hospitals have been by-products of the development of these specialties and the growth of the modern hospital. The evolution of the specialties has been from the nonprofessional services of technicians or nurses, for which the hospital has charged —and quite properly so. Today the services of the anesthesiologist, the radiologist, and the pathologist have been recognized by the medical profession and by the courts as the practice of medicine when such services are paid for by the patient.

Concurrently with the development of these specialties as professions has evolved the large-scale hospital with its modern installations and facilities for the practice of these specialties. Problems of rising costs of hospital care and the necessity of balanced budgets have not contributed to easy solution of the problems accompanying this dual evolutionary process. Talking in terms of the corporation making a profit off the services of the specialist does little to clarify thinking in this field. A more sound approach is the one used by the courts in resolving these questions in terms of who can and who cannot perform and charge for professional services.

DIFFERENCES IN THE SPECIALTIES

While the hospital administrator will recognize that the specialist as well as the surgeon engages in the practice of medicine, I think he instinctively feels that they are different.

It is often suggested that the huge investment of the hospital in its laboratory or radiology department creates for the hospital a different problem in its relationship with these specialists. Certainly no one expects the hospital to furnish its facilities without compensation. But this suggested basis of differentiation in the relationship with the specialist is without validity.

Another suggested differentiation is the remoteness of the specialist's relationship with the patient as contrasted with that of the surgeon or other practitioner. To the uninitiated, the concept of the patient's free choice of physician makes little sense when applied to the specialties. However, the existence or nonexistence of the patient-physician relationship does not turn upon the mechanical act of designation. Again the suggested differentiation lacks validity.

Most of the commonly voiced reasons as to why the radiologist or other specialist should be treated as a different kind of doctor find their roots in the historical struggle of the specialty to achieve professional status.

Another apparent differentiation between the role of the specialist and the surgeon or other practitioner is the franchise or apparent monopoly conferred upon the specialist.

POSSIBLE APPROACHES

It is proper that the hospital be paid for the use of its equipment and the services of its technical personnel. Since the furnishing of such services does not constitute the providing of diagnostic or other medical services there is no legal impediment to the hospital's making such a charge to the patient, recognizing that the charge for professional services must be that of the doctor. Improvements in hospital cost accounting give hope of facilitating that task.

The lease of hospital equipment to the specialist on a fixed amount or percentage of income basis has been suggested as a means of compensating the hospital for its contribution. I do not find serious legal difficulties with this suggestion from the standpoint of the doctor. From the standpoint of the hospital, however, I have some serious concern over the tax exemption statutes and decisions of the particular state which may be involved. I find more difficulties however, with an arrangement where the hospital and the doctor split on a percentage basis the proceeds of a single bill to the patient for the professional services of the doctor and the technical services or equipment furnished by the hospital. A court may well conclude that the hospital and the specialist are in partnership to supply both professional and technical services and to divide the profits between them—a conclusion which would involve the hospital in the illegal corporate practice of medicine. A safer arrangement would be separate charges for professional and nonprofessional services. There are practical difficulties in such a course, but there are potential legal difficulties in any other course.

A word remains to be said with respect to the franchised position of the specialist. Certainly the hospital and its staff as well as the patient are entitled to be protected against any abuses which may flow from a monopolistic position which the specialist may enjoy. My belief is that control of the professions themselves is the best guarantee against excessive fees. Further, in control of staff privileges lies a most effective protection against abuse of the patient through excessive fees. In this connection it should be added, however, that the legitimate concern of the hospital is not how much money the specialist makes but whether or not his fees to the patient are fair and reasonable.

It is my firm belief that the limiting of entrance into the field of any specialty or other branch of practice will inevitably limit the professional standards of that specialty. The supply and quality of the practitioners is inevitably interrelated with the problem of adequate staff openings to attract competent men to the field. With the attainment of full professional status, it seems to me that the specialist will rise or fall upon his own merit and abilities. Hospitals, their staffs and patients are entitled to the services of the best of those practitioners who can be attracted to the specialties.

Conclusions of today in the rapidly changing field of the medical specialties have validity only as they stand the test of time. To the extent that they are predicated upon valid premises they may rise above the role of guesswork. ■

RADIOLOGIST

(Continued from page 47)

It is to preserve and protect the rights of patients that codes of medical ethics and medical practice laws have been developed. It is because hospital people, and all too many physicians, have failed to understand the reasons behind all this, and their implications, that present misunderstandings have developed.

In the mid-forties I was invited to discuss this subject at a meeting in Portland. In the subsequent discussion, a state hospital association official said, "I think its time you doctors forgot all this nonsense about medical ethics and started to get practical." By being practical he meant that the hospitals should hire physicians and sell their services to the public.

NEW LAW PASSED

Even at that time, such a procedure was contrary to law in our state, as in most. Later, however, a new law was passed that made it a crime on the part of the hospital, and grounds for revocation of license on the part of the doctor, for a physician and a hospital to split a professional fee. Since this was common practice, a committee of radiologists, pathologists, and anesthetists asked to meet with hospital representatives to see if mutually acceptable ways could be devised whereby the law could be observed without damage to the already precarious financial position of the hospital, and without unjustified financial burden on the patient. It should be possible. We were told, however, that our proposal to seek such an arrangement was not made in good faith, that we were merely trying to upset long established arrangements, and trying to rob the hospitals of what was rightfully theirs. They wouldn't even discuss, or entertain the thought of *any* change.

After more than three hours of being called everything in the book, I finally said: "Well what are we to do? The law is on the books, and you can't expect us to continue with arrangements that make us liable to revocation of our licenses." The answer, from the legal counsel of our state hospital association, was: "I would advise you to ignore the law. It will be repealed by the next legislature anyway."

The law was not repealed, much less the basic medical practice law; but both are being ignored, not because the hospital lawyer told us to, but because he has told the hospitals to. We, on the other hand, have not been willing to make a public controversy of something which should be resolved by mutual understanding, and when making the issue would do irreparable harm to public esteem for both doctors and hospitals.

The law and the codes of medical ethics are human instruments and fallible; both can, and should, be changed whenever it appears that present forms are failing to achieve their purpose. On the other hand, their purpose must never change, and that is to preserve and protect the rights of patients.

In general, hospital trustees and administrators are capable and conscientious men, performing an important, difficult, and often thankless task. And when they disregard medical law and ethics, and over-ride all opposition, they honestly believe they are doing right and that it is in the public interest. How can this be?

The explanation is not hard to find. They know that better hospital services can be provided more cheaply when properly organized and efficiently administered, and they believe the same can be true of professional services rendered in the hospital. We hear over and over the statement that the hospital should assume its rightful place as dispenser of medical care to the community. If it were true that better medical care could be provided more cheaply that way, we should have to agree.

On the other hand, the Supreme Court of the State of Washington has twice quoted with approval a dictum of the South Carolina court that a corporation or an unlicensed person may not practice by the expedient of employing a licensed practitioner and selling his services, saying: "If such a course were sanctioned the logical result would be that corporations and business partnerships might practice law, medicine, dentistry or any other profession by the simple expedient of employing licensed agents. And if this were permitted professional standards would be practically destroyed, and professions requiring special training would be commercialized, to the public detriment. The ethics of any profession is based upon personal or individual responsibility. One who practices a profession is responsible directly to his patient or client. Hence he cannot properly act in the practice of his vocation as an agent of a corporation whose interests in the very nature of the case are commercial in character."

HOSPITAL PEOPLE UNIMPRESSED

Hospital people, by and large, have been wholly unimpressed by these statements. They do not believe "commercial" applies to them, particularly in the case of the nonprofit hospital. But regardless of the word used, the hospital is engaged in selling a product to the physician's patients; the fact that the product is called "hospital services" does not alter the commercial nature of the transaction.

To all appearances what the hospital sells and what the physician charges for are completely analogous, and it is not surprising that most hospital people and all too many doctors are unaware of the difference. Nowhere on either bill is an item labeled "professional responsibility," "medical judgment," or "expert advice." In the case of the hospital, this is proper since a hospital is not capable of providing these things. In the case of the doctor's bill, the absence of these items is grossly misleading, since these are what the physician is employed to provide. All the other services are merely incidental to the primary service.

Advice *not* to have a particular operation is frequently a far more valuable "service" than the performance of the operation. But this is a service that never appears on the itemized bill from either the hospital or the physician, and that neither the hospital nor any other organization is in a position to provide.

So far as I know, the only right of the specialist which people in the hospital field overlook is his right to the complete freedom

(Continued on page 126)

LEFT: A large, cheerful playroom, which in summer may be opened onto a wide sundeck, allows ample space for convalescent children to gather for movies or other entertainment. Here in a corner of the playroom, a Red Cross Gray Lady entertains two patients while in the background a father and mother await the return of their child from surgery to his room. BELOW: A young patient is comforted by being held in her mother's arms and rocked in an old fashioned rocking chair.

a hospital for children and their anxious parents

by MOIR P. TANNER

THE CHILDREN'S HOSPITAL of Buffalo, N. Y., like many other hospitals, had expanded over the past half-century until it became neither adequate nor effectual.

In 1953 the hospital embarked on a $4,750,000 program which included remodeling three buildings, razing a fourth, and construction of a three and a half million dollar pediatric building. The recently completed 10-story pediatric building was dedicated in February of this year.

Starting at the top floor, the various departments in this building are allocated as follows:

The 10th floor contains ventilating and fan equipment, elevator machinery and other usual penthouse encumbrances.

The ninth floor, devoted to the care of contagious cases, has 24 beds in individual rooms, each with adequate scrub facilities. A special feature is sliding partitions which can be opened up, keeping corridor doors closed, to make a nursing unit for several patients with the same disease. The floor

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Moir P. Tanner, F.A.C.H.A., is director of the Children's Hospital of Buffalo, New York.

contains, besides a conference room, its own operating and x-ray rooms, making it unnecessary to expose other children to infection while taking patients to common units for procedures.

The eighth and seventh floors are 30-bed medical units, one for older children and the other for infants. All rooms contain one, two or four beds. These floors include conference rooms for house staff, medical students and student nurses as well as a large laboratory for the medical students. Treatment rooms make workable areas for care of acutely ill children.

One half of the sixth floor will remain unfinished until funds are made available for it to become a convalescent unit. The other half of the floor is used by the Sister Elizabeth Kenny Foundation for treatment of children for whom it is responsible.

The fifth floor is a 32-bed semi-private unit for care of medical and surgical patients, with again the necessary adjuncts for play therapy and treatment, and special rooms near the nurses' station for critically ill children.

The fourth floor is a 24-bed private nursing unit, each room having its own lavatory.

The third floor, a 37-bed surgery and orthopedic department, is the only floor on which there are nursing units of more than 4 beds. With the belief that children convalesce better together, two 8-bed units have been installed. A large playroom where children may gather for movies and other entertainment opens onto a spacious sundeck.

The completely air-conditioned second floor contains the hospital's surgical suite equipped with spark-proof conductive tiling and explosion proof outlets. Elevators are so situated that surgeons can go from the staff entrance directly to their lockers into the surgical unit without delay. There are eight operating rooms, one with a gallery and speaking devices for teaching; x-ray for the general use of patients in surgery, and another for endoscopic work; a dental room; pathological laboratory; and the usual adjuncts for nurses and surgeons. Nurses' work and supply rooms occupy the core of the surgical suite which is connected to a large 12-stretcher recovery room.

The first floor has a generous staff room, a medical library and an occupational therapy room built to resemble a small village, which is distinctive and adds emphasis that this is a children's hospital. There is also a large air-conditioned auditorium extending from basement to ground level which seats 160, a dining room accommodating 150, and a snack bar installed and operated by the Junior League of Buffalo.

The basement, like all basements, contains locker rooms, storerooms, equipment rooms, and, one of our greatest needs, a large, well-designed, stainless steel kitchen which replaces three outmoded ones in other buildings.

PLANNING

In planning a hospital for children, our first responsibility naturally was to the patient. Great use has been made of glass. All rooms and wards are separated by glass partitions for three reasons, and it is difficult to say which is the most important: (1) to obtain the maximum light; (2) for ease of nursing; (3) so that a child will not feel as much alone. When privacy is desired, curtains on tracks installed above the glass may be drawn.

Engineers have given greater thought to ventilation of this building than is customary in ordinary hospital construction. Piped oxygen and suction are available to over 90 per cent of the beds.

In thinking of patients in the younger generation, great care was exercised in locating clinical departments. These are all located on the second floor of two buildings which remodeling will join together. It will not be necessary for patients to go on any other floor, whether they are private ambulatory cases, inpatients, or outpatients required to visit these clinical units.

In designing a pediatric hospital parents deserve all the consideration that planners can give them. For example, there are two elevator banks, one at each end of the pediatric building, but the one used by parents opens into a small lobby-waiting room on each floor. Opening off the lobby is a separate room for private consultation between doctor and parents or clergyman and parents, which may also be used as a refuge by grieving relatives. Other conveniences available on all floors for parents, such as their own lavatory and telephone, are thoroughly appreciated. Each private room has a small davenport which opens up into a bed where a parent may stay with her child overnight. Throughout the building, cupboards which run along the outer wall have been used to eliminate the need for built-in metal lockers.

Small bedrooms have been designed for use of parents only. If a physician recommends that a

parent remain in the hospital overnight, even though her child may be in a ward, there is a place for her to stay. If a parent from outside of the city brings a child to the hospital in the middle of the night, he need not search the city for sleeping accommodations.

Other provisions for parents' comfort include availability of meals in the hospital dining room or Junior League snack bar, appropriately called "The Hi-Chair," and a unit to be constructed in the hospital's large lobby where they may leave their children under supervision while visiting patients. A children's hospital lobby on a Sunday afternoon may easily become an Alamo for young Davy Crocketts.

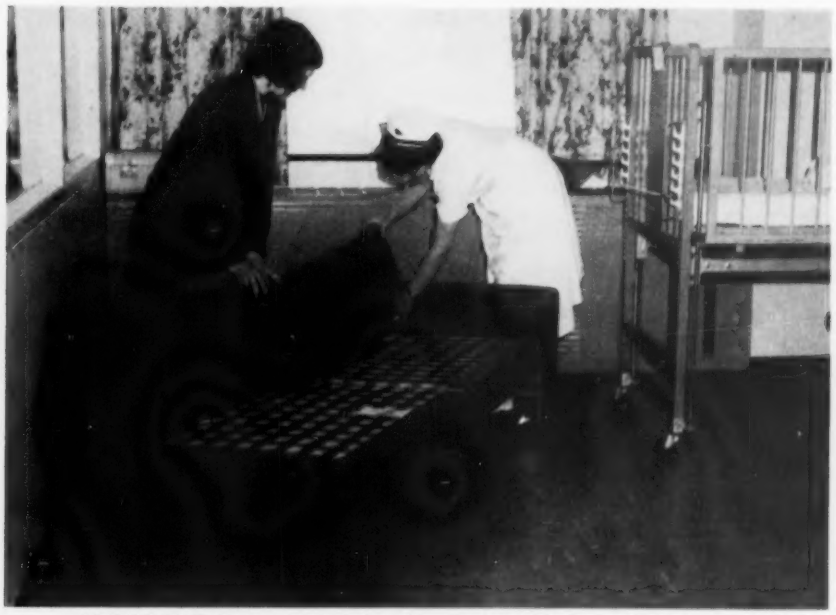
Consideration of physicians' requirements is particularly important in planning a pediatric unit. The new building, therefore, provides more and better private accommodations as well as more ward space with separations for medical cases.

Special nursing facilities incorporated in the planning include rooms next to nurses' stations on each floor for seriously ill children; pneumatic tubes connecting with medical record room, cashier, pharmacy, central supply, and other units; a lift from central supply to nurses' stations making it unnecessary for nursing personnel to go to this basement unit for sterile equipment. Private accommodations for the nursing staff are available at each station and three bedpan units on each floor conserve steps.

The office of the director of nurses is on the first floor, off the main lobby. Its location, only a step from the elevators which transport nurses to upper floors for supervision, or down to the nursing office on necessary errands, saves time and energy.

A combination laboratory-chart room next to the nurses' station is available on each floor for the house staff. One wall of these small rooms contains a laboratory desk where common procedures may be carried out, the other, a chart desk. Between the nurses' station and doctors' room is a circular revolving chart rack which makes charts readily accessible to both nurses and house officers.

Conference rooms are located on all floors for the use of house staff as well as for others in the large army of physicians and students that a pediatric teaching unit for a medical school needs.



OPPOSITE PAGE: Parents are invited to share the hospital's new cafeteria (seating 150) with members of the staff and thus need not go out to have a hot, nourishing meal.

ABOVE: Advised that she may spend the night with her baby in a private room, a mother is shown how to convert a davenport into a full-sized single bed.

BELOW: A father and mother await their doctor's report of his examination of their sick child while seated comfortably in one of the waiting-lobby areas. In a private consultation room, another mother discusses her child's progress with a resident physician.

REMODELING

While 75 per cent of the hospital's program has been completed, the rest of the work—the remodeling—continues and, according to present schedules, will be finished late this fall.

The second floor of the former main building, remodeling of which has now been completed, will be used entirely for house staff quarters. Instead of living in converted private houses this staff now will have the modern accommodations which they deserve. Medical students have separate lockers and lounge rooms which, until now, the hospital had been unable to provide.

Remodeling will bring from the basements of three buildings accounting, payroll, credit, and cashier offices. It will make available many conference and classrooms for teaching, in addition to those on patient floors. It will give the hospital an adequate medical record department, a

(Continued on page 124)

national clearing house program for blood banks

. . . what it is . . . how it works

by BERNICE M. HEMPHILL

IN DECEMBER OF 1954, the American Association of Blood Banks announced its national clearing house program. This program was established so that blood service can be extended from one blood bank to another for the benefit of donors and patients.

The program is being implemented through a network of five nonprofit district clearing houses, located in San Francisco, Chicago, Dallas, New York,[1] and Jacksonville. Each of these clearing houses serves a designated section of the country and has a membership consisting of community and hospital blood banks located within its boundaries. The governing board of each clearing house is composed of blood bank representatives appointed from within its district.

Patterned after a clearing house for monetary banks, these central offices function primarily as bookkeeping agencies for member banks to provide the following basic services:

1. **Handling** the exchange of donor replacements between blood banks.
2. **Facilitating** the borrowing and lending of blood between banks, wherever and whenever needed.
3. **Keeping** records, balancing accounts and arranging settlements to cancel interbank indebtedness.
4. **Engaging** in such auxiliary services as are best conducted through a central agency.

To defray the expense of operating each clearing house, member banks pay transaction fees.

DONOR CREDITS TRANSFERRED

The most important function of the clearing house program is the handling of donor replacement credits when blood donations are made in one part of the country for specific patients hospitalized in another area. For instance, a resident of Minneapolis may be hospitalized as the result of an accident in Chicago and receive several transfusions. Since his relatives and friends are in Minneapolis, it would be difficult for the patient to secure donor replacement in Chicago. However, through the clearing house program, the relatives and friends of the patient may give their blood at the bank most convenient to them, furnishing the name of the recipient and the name of the hospital, and the city where the transfusions were administered. The bank accepting the donations forwards a reciprocity credit form to its clearing house for channeling to the bank that supplied the blood. In effect, the reciprocity credit form is an "IOU" from one blood bank to another. It verifies the acceptance of replacement donors and enables the patient to receive credit just as if the donations had been made at the bank which furnished the blood.

Another service of the clearing house program is the charting of

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Bernice M. Hemphill is chairman of the National Committee on Clearing House for the American Association of Blood Banks; and managing director of the Irwin Memorial Blood Bank of the San Francisco Medical Society.

1. The district clearing house in New York is in the organizational stage.

surplus blood and the directing of shipments to alleviate reported shortages. By keeping an inventory of blood surplus among the banks it serves, the clearing house relieves its members of the necessity of contacting several banks in an attempt to find the right type of blood, and minimizes the outdating of blood for those banks that have an unavoidable surplus.

Member blood banks do not have reciprocity accounts with each other. They maintain one account with their clearing house. All "IOU'S" and debts that occur from the borrowing and lending of blood are reduced to a net balance whereby banks are indebted to the clearing house, or vice versa.

HOW DEBTS ARE SETTLED

Such indebtedness can be settled by blood shipments, payment of donor fees or a combination of both. The clearing house predetermines how each bank wishes to settle its debts, sends out monthly statements showing the net amount of blood due and directs settlement in blood or money. Whenever a blood bank receives more blood than it has shipped within a given period, it must pay to its clearing house a processing and transportation fee for each excess unit. In turn, the clearing house remits these fees to banks that are required to make blood shipments.

The Pacific District Blood Bank Clearing House, formerly the California Blood Bank System Clearing House, has been in operation for five years. During this time it has served 19 member banks and maintained reciprocal relations with Red Cross Regional Centers and many other community and hospital blood banks throughout the country. Its statistical experience depicts the advantages that blood banks derive from participating in a clearing house program. Since 1951 it has processed 99,466 donor replacements and arranged for blood banks to borrow 13,821 units of blood. To settle the indebtedness that developed from this exchange of 113,287 individual transactions, a total of 24,955 units of blood and/or paid donor fees were required. This figure represents only 22 per cent of the total individual transactions. The majority of banks paid their indebtedness by shipping 23,931 units of blood; however, a few banks settled by paying 1,024 donor fees.

The clearing house may act as a central agency for its members and perform additional services, such as:

1. To conduct surveys on various blood bank activities.
2. To facilitate the salvaging of outdated blood into derivatives.
3. To act as an agent for banks in the collection and processing of blood for defense and disaster.
4. To perform other activities related to blood banking.

Participation in the National Clearing House Program is entirely voluntary. Membership is open to all hospital, community or private blood banks whether or not they are members of the American Association of Blood Banks. No membership fee is charged, but the cost of operating each clearing house is borne by its member banks. This is accomplished by charging members a fee for each donor replacement credit and unit of blood handled for them. Official clearing house reciprocity credit and blood shipping forms are provided to all members, and these forms provide the basis for clearing house operations.

PLAN ASSISTS REPLACEMENT

The increased demand for the exchange of blood credits has been impressive, and it may be interpreted as a willingness, if not an eagerness, on the part of the public to use this means of replacing blood. It is a fact that when relatives learn of the sudden illness of one of their family they wish to do everything possible to help the sick person. If these relatives can be told that regardless of where they are throughout the country, they may serve as blood donors, it will be possible to achieve a greater replacement of blood. All blood banks should provide this service to the public.

Experience is showing that the clearing house program enables banks to provide blood for patients more adequately, economically and efficiently, and it promotes good public relations between patients, donors, blood banks, hospitals and the medical profession.

Technical and administrative difficulties arise, but these difficulties are resolved when participating facilities understand interbank reciprocity and the basic principle that its operation is predicated on mutual need and trust.

Blood banks interested in having additional information about membership and the operations of the National Clearing House Program should contact the designated clearing house for their area. A list of these district clearing houses follows:

1. North Central District: Illinois, Indiana, Iowa, Kansas, Kentucky, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota and Wisconsin.

NORTH CENTRAL DISTRICT BLOOD BANK CLEARING HOUSE
185 N. Wabash Avenue
Chicago, Illinois

2. North East District: Connecticut, Delaware, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, Washington, D. C., Virginia and West Virginia.

(Now organizing—to be located in New York City.)

3. Pacific District: Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, Oregon, Utah, Washington and Wyoming.

PACIFIC DISTRICT BLOOD BANK CLEARING HOUSE
270 Masonic Avenue
San Francisco, California

4. South Central District: Arkansas, Louisiana, Mississippi, New Mexico, Oklahoma and Texas.

TEXAS ASSOCIATION OF BLOOD BANKS CLEARING HOUSE
3707 Gaston Avenue
Dallas, Texas

5. South East District: Alabama, Florida, Georgia, North Carolina, South Carolina and Tennessee.

SOUTH EAST DISTRICT BLOOD BANK CLEARING HOUSE
P.O. Box 2085
Jacksonville, Florida

The establishment of a National Clearing House Program is a step toward improving blood collection and distribution, standardizing equipment and procedures, and the development of a network of efficient and cooperative blood banks to serve the nation in time of peace or war. ■

microfilming—solution or stopgap?

More and more medical records to store in less and less space is a problem confronting many hospitals

by HELEN C. CHASE

THE PROVISION of space for hospital records has become a serious problem. Before the development of microfilm, older records were often relegated to cellars, attics or other undesirable and inaccessible storage places. Some hospitals, unable to find space within their own buildings, rented extramural space and transferred their older records out of the hospitals.[1] Such methods increased the financial burden of the hospital in terms of added rent and personnel time spent in recovering remotely located records.

The solution to the problem lies in reducing the volume of accumulated records in one or more ways: destruction of old records, destruction of parts of all records, or reduction in the size of each record. Two basic methods are available: records disposal and microphotography.

That microfilm solves the storage problem by reducing existing volume is unquestioned. But it has merely postponed an attack on the more basic questions: How long shall a hospital be required to save its records? Is it necessary to "save them indefinitely"? Is it necessary to save all of them 25 years?

Helen C. Chase was a Public Health Service research fellow of the National Heart Institute, at the School of Public Health, University of California, Berkeley, at the time this article was written.

REASONS FOR RETENTION

There are no legal requirements regarding the maintenance or duration of retention of a hospital record. The desire to save hospital records existed before the hospital accreditation movement, so that accreditation cannot be the only stimulus. The emphasis on maintenance of records for adequate patient care bolstered the concept of the value of the record. The standards of the Joint Commission on Accreditation of Hospitals do not specifically order perpetual maintenance, whereas they are specific as to accuracy, completeness and accessibility of hospital records. Therefore, the practice of retention of all records for unspecified long periods of time apparently sprang from self-imposed regulation by the hospitals themselves. This practice stemmed from three reasons: (1) self-defense in lawsuits involving the hospital; (2) service to the patient and community in keeping the record available for imponderable eventualities; and (3) lack of guiding opinions and advice regarding the disposability of hospital records.

Legal opinions affect the retention of hospital records in unexpected ways.[2,3,4,5,6] Most states have a statute of limitations which specify the period during which a suit for damages may be instituted; for example, three years or seven years. The courts in some states have decided that for minors this period may begin when the minor attains his majority. Based on such decisions, some hospitals feel that records for newborn infants should be kept for 25-30 years, even though 99 per cent of the records will probably not be consulted after five years. Prolonged retention rapidly creates a storage problem.

The question "is it necessary to save the records indefinitely?" can be examined in the light of the uses and purposes of hospital records. For each purpose, how long must the record be kept?

1. Patient care: The record has usually fulfilled its purpose when the patient leaves the hospital, although it is sometimes needed again at the time of readmission. It has definitely served its purpose when the patient dies. In general, as the period from last discharge increases, the value of the record decreases.

2. Hospital statistics: This purpose

AT THE 230-bed Nashville (Tenn.) General Hospital, medical record librarian Willie Mae Kemp is shown with the single cabinet which houses the hospital's microfilmed medical records.

is fulfilled shortly after the patient is discharged, probably at most within a year.

3. Legal actions: Actions brought by adults must be instituted within a fixed time period, perhaps three or seven years. In the case of a minor, this period may not begin until he has attained his majority. It therefore appears that for reference in legal action 25-30 years is the maximum retention period for the records of newborn infants, and 10 years is the maximum retention period for adults. It should be noted that these are maximum, and not necessarily optimal, periods of retention.

4. Medical education: The emphasis here is on teaching modern medical techniques. Therefore it is probable that only records of the past 5 or 10 years are necessary.

5. Research: Although theoretically it is possible to carry on research based on records 100 years old, hospitals find that requests for records for research purposes are generally for recent years. For this purpose, then, it appears that maximum retention for 20 years would suffice.

6. Medical audit: In order for patient care to derive the maximum benefits from the medical audit, the medical audit should be conducted soon after the patient leaves the hospital. For this purpose the records lose their usefulness relatively soon, perhaps within a year.

In the various accounts of hospitals which converted to microfilm, there is little mention of an objective attempt to measure reference to medical records. One report indicated that 80 per cent of requests were for records within three years of the patient's discharge.[7] It is safe to assume that beyond three years the requests decrease as time from discharge increases. This matter is worthy of additional quantitative study.

Although the microfilming of complete medical records has found wide acceptance because of the saving of space and its accompanying cost, the solution to the basic problem "how long should records be kept?" has not been answered objectively. In 1946, Carter and Sutton suggested that the original record be destroyed after 25 years, and a factual card retained.[8] They suggested that this card should include meager data such as, name, age, sex, date of admission and discharge and operative procedures. The value of retaining this information also needs evaluation. If there is no reason to save records more than 25 years, does the hospital need to make a record of the original before destroying it? How often are these cards used? For what purposes? The time interval suggested was based on the maximum period listed under "purposes" above. Is a uniform period of retention necessary for all records?

DISPOSAL OF RECORDS

The idea of disposal of records has caught hold sufficiently to be adopted in many hospitals.[9] Before microfilming, it appears logical to think in terms of disposal:

1. Do we have any records which we can throw away completely? For what period of time should the various categories of records be kept? (For example, clinic records, records of routine deliveries, tonsillectomies.)

2. Do we have any records which we can throw away in part? Some hospitals put nurses' bedside notes in this category.

3. For retained records, which form of microphotography will be best suited to our purposes? Which case numbering system shall we use to permit future disposal of records?

Answers to the first two questions should be ascertained before considering the third. Unfortunately, sometimes the sequence is reversed, resulting in many reels of film which in all probability will never be used.

In the orderly progress of the development of the science of hospital management, the attitude toward record retention has progressed from lack of planning (perpetual retention) to stopgap planning (retention for a maximum period). The next step in this progression is an objective review of the utilization of hospital records to determine an optimal period of retention.

The problem of record disposal is subject to statistical review. By listing the records requested during some period of time, an accurate and objective picture of referral to hospital records can be obtained. The year of most recent discharge, year of birth, and a one-letter code denoting the reason for the request (for example: R—readmission, M—medical research, A—medical audit, E—medical education) constitute the basic information. If a more detailed analysis is desired, the diagnosis on discharge, the service or department requesting the record may be included. This information, obtained from a representative group of hospitals, will lend itself to the development of an objective policy regarding record disposal. The policy may well vary with the type of hospital, with modifications for teaching hospitals, special purpose hospitals and general hospitals.

The time has come for hospitals to attempt to answer the question regarding the *optimal* period of retention on a cooperative basis, pooling their experience to arrive

(Continued on page 130)

***Robert P. MacFate, Ph.D., writing in the* Illinois Medical Journal**

—medical records

"A hospital record is like a will in that, many times, it will be read and an attempt made to interpret the statements therein, when the original writer is not present. Each statement in the record, therefore, should be written with the thought in mind—can someone else, not familiar with this case, read this statement and know exactly what the writer meant to say."

a *safe* hospital is no *accident*

by W. A. HACKER

SAFETY IN the hospital is not a new or "extra curricular" activity for the administrator, but merely an extension of his normal and necessary administrative effort. As he supervises his personnel and coordinates their activities, he naturally tries to indoctrinate the idea of safety for the protection of life and property.

The employee in the hospital is entitled to the same protection he would receive in industry. In addition, precautions must be taken so he will not be unduly endangered by contact with patients with contagious or infectious diseases.

The hospital administrator simply cannot afford to have an unsafe hospital. The loss of a building, the destruction of equipment, even though covered by insurance, means replacement at a higher cost. In the meantime, there is a reduction in income if the loss occurs in a diagnostic or therapeutic area, or an increase in cost if the loss occurs in a service area, such as a laundry where substitution must be made by buying the service from the commercial markets.

The institution of a good fire prevention and control program costs money, too. But sometimes, as in the installation of a sprinkler system, the expenditure is recovered within a few years in reduced fire insurance premiums.

Accidents to employees cost money directly, when the hospital buys the type of insurance in which the premium is based on lost-time experience, and indirectly, because of the inefficiency and slower production of employees who stay at work after being injured, and the cost of training new employees to replace those who lose time.

FEWER IMMUNITY STATES

In Pennsylvania the charitable institution is exempt from malpractice suits when a patient suffers injury through the negligence of its employees. However, more and more states are allowing legal recourse in these cases.

Personnel studies have revealed that salary is not always the main consideration in recruiting and holding good employees. A safety program carried out through a committee comprised of representatives from all departments, and organization of a fire brigade, utilizing men from the housekeeping, laundry and maintenance departments, serve not only to provide protection for the hospital, but also afford these persons an opportunity to feel that they are a part of the hospital team. The scrubber who has had half an hour's instruction in how to carry out a patient in case of a fire begins to know his job is important and that he, too, is responsible for the welfare of the sick and injured in the hospital. The nurse who experiences fire drill procedures has a feeling of confidence with regard to her patients.

The wall washer is instructed to turn off the germicidal lamps while he is cleaning the ceiling to prevent inflammation of his eyes; the maintenance man is required to wear goggles while welding; the nurses and technicians have a chest x-ray annually—all such practices show the hospital's interest in the health and welfare of its employees and improve personnel relations.

The same is true of public relations. The hospital people praise the hospital to their friends and neighbors; the newspaper publishes pictures of a fire drill; a child gets a plastic tube "so you won't bite it when you drink your milk." The word gets around—"they take good care of the patients and the employees at the hospital."

The Joint Commission on Accreditation of Hospitals expects the hospital to meet certain basic requirements for protecting the patient from cross infection and to have an emergency plan for protection in case of fire. It suggests that the hospital have a well rehearsed disaster plan, provisions for power failure and so forth.

Granted that the administrator must have a safety program, what are the problems involved? The variety depends on the individual institution and upon the extent to which it performs or purchases the many services involved in the operation of a modern hospital.

The administrator has the obligation to provide a safety program which covers not only the hazards common to industry but those peculiar to hospitals. He has three distinct groups to consider: (1) the patients, (2) the employees and (3) the public.

To devise an effective safety program the administrator needs, first, the support of the board of trustees. Many of the board members will appreciate the need for such a program since they have

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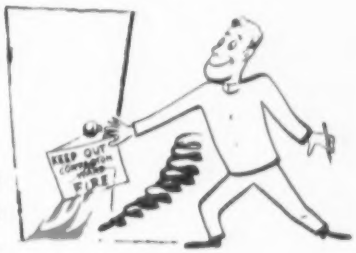
W. A. Hacker is administrator of the McKeesport (Pa.) Hospital.

This article is adapted from a paper presented at the 30th Annual Western Pennsylvania Safety Engineering Conference and Exhibit.

four steps to fire safety

FIRST: *The safety of the patient comes first.* If a patient is in immediate danger, remove the patient to safety before doing anything else.



SECOND: *Confine the fire* by closing doors.

THIRD: *Send the alarm.* Pull the nearest alarm box; this notifies the central switchboard operator.

The alternate alarm is a call to our switchboard—Dial Red 0—Operator; this call should be made promptly even if the alarm has been pulled at the alarm box, and the line kept open so the operator can be kept informed as to what is happening. If power failure has knocked out telephone or alarm system, or both, as messenger must be sent to Control Center at Mayo main lobby.

FOURTH: *Fight the fire after closing all room doors and reassuring patients.* Fire extinguishers are located on wall fixtures and in wall cabinets; and if you can put one into operation before a fire has gotten out of hand, you may be able to extinguish or subdue it very effectively.

If you are not a trained fire fighter or fire brigade member, be careful about taking unnecessary chances with a fire.

These points are important:

(a) Always stay between the fire and the way out to safety.

(b) Crouch low to avoid smoke and heat.

(c) Aim the extinguisher at the base of the flames.

(d) Avoid inhaling smoke and fire gases.

These illustrations and copy are from a booklet describing the fire emergency plan used at the University of Minnesota Medical Center.

safety programs in their own enterprises. Others will question the cost and will have to be convinced of the need. After having gained the support of the board of trustees, the administrator must translate the idea into a definite policy and win the support of his staff.

In the very small institution, the administrator may prefer to devise and direct the program himself. However, he will probably win more cooperation if he "gets everybody into the act." The first step will be the organization of a safety committee with representatives from all departments and perhaps some outsiders, particularly a member of the local fire department. The administrator then guides his committee in the formation of an over-all plan, with three phases: employee health, fire prevention and control, and accident prevention.

The employee health program, beginning with a pre-employment examination, minimizes hazards from the start by eliminating applicants who would not be able to perform their duties safely. The pre-employment examination —including, as a minimum, a physical examination, a chest x-ray, blood tests and urinalysis—protects the prospective employee, his fellow workers and the patients. Since employees are frequently exposed to patients with tuberculosis in the general hospital, an annual recheck chest x-ray is advisable; and after a prolonged illness or repeated absences due to illness, another physical examination should be required. These measures will insure a healthy staff that presents a hazard neither to one another nor to the patients.

FIRE SAFETY PROGRAM

A fire prevention and control program is another phase of safety, which, if practiced rigidly, will benefit all—the employees, the patients and the visitors.

Every known hazard should be eliminated. All employees should be educated to watch for and report any source of danger such as defective wiring and equipment. Smoking habits are dangerous. "No Smoking" signs should be posted in danger areas; smoking rooms should be provided for employees to minimize surreptitious smoking; deep ash trays should be readily available; and patients should be instructed to be very careful.

Control depends first on prompt alarm. Every employee should know where the fire boxes are located and how to operate them. There should be an efficient, foolproof way to alert all personnel.

Everyone should know how to operate a fire extinguisher and what his duties are when the alarm sounds. Frequent drills will make his reactions automatic.

Finally, a written evacuation plan should be developed and practiced.

The accident prevention program, actually, is a part of the job training program. When an individual is taught how to do a job, he should be taught how to do it safely—for his own protection as well as that of his fellow workers and the patient. How to lift, how to handle tools, how to protect himself from burns, chemicals, x-rays, are all a part of the employee's education in doing his job safely.

There is plenty of material available from the American Hospital Association, the National Safety Council, the National Fire Protection Association and the departments of labor and industry which the administrator can and should use in planning his safety program.

Two of the best tools for making the program effective are inspections and records.

Inspections are made, of course, by licensed inspectors from the departments of labor and industry or similar authorities in various states, and the Board of Fire Underwriters. Their recommendations should be carried out and their suggestions given serious consideration.

In addition, regular inspections should be made by members of the safety committee who should use a check list to assure that hazards are eliminated and deficiencies corrected.

Written records tell the administrator whether or not his program is effective.

Accident reports should be submitted for employees, visitors and patients, stating the nature of the injury, what the person was doing when the accident happened, what caused the accident, where it occurred, and how the accident could have been prevented.

A tabulation of information thus collected may reveal some startling facts. A survey in a hospital of 450 beds and 75 bassinets disclosed the following facts for the year 1954:

There were 219 accidents to patients. Eighty-seven adults and 28 children fell out of bed; 62 slipped and fell on the floor; 22 fell out of wheel chairs and 3 from ordinary chairs; 12 fainted. The other 33 were miscellaneous accidents.

FEW ACCIDENTS SERIOUS

Few of these accidents caused serious injury. In fact, some received no injury; most suffered merely minor bumps or bruises. However, personnel should be instructed to report *all* accidents, no matter how trivial, so that corrective measures can be taken to prevent recurrence. A serious injury *could* result from *any* accident.

Employees and graduate nurses in our hospital number 750, and there are 105 students in the school of nursing. This group suffered 210 accidents, mostly minor. Twenty-nine were falls; 28 were cut with broken glass; 40 were cut with tools and sharp objects; 20 bumped into furniture and other objects; 17 were burned by fire or hot objects, and 4 by chemicals; objects fell on the hands or feet of 19; 19 had foreign bodies in the eye and 6 had splinters in their fingers; 5 had contact dermatitis; and 13 had miscellaneous accidents. Fifteen of the above were lost-time accidents.

Twenty-seven visitors were injured. Falls figured high in the causes—14 slipped on the floor, 3 fell on the grounds, 2 fell down steps; and 3 fainted. The others were miscellaneous accidents.

Obviously, a recapitulation of a hospital's accident experience such as this proves the need for a safety program. It is not enough for the administrator to have the facts. He must provide the machinery to prevent or greatly reduce this large number of accidents; otherwise his record will be the same, or even worse, the next year. ■

THE 1956 CONVENTION IN REVIEW

CHICAGO GREETED THE 58th convention of the American Hospital Association in mid-September with some of the finest September days in weather bureau history. There was a touch of autumn and the days were sunny, the skies were clear. Those who live in Chicago felt that the city's lakefront skyline gleamed against the blue as never before.

That is about the way the convention went, too. The atmosphere was generally bright and optimistic. And like the skyline, most problems and their potential solutions seemed to stand out more clearly, somehow, than they had before. This was by design. For the Association had brought together a group of speakers whose sole charge had been to focus the spotlight of reason upon the problems of planning for the future in hospital care.

Inside the cavernous International Amphitheatre, on the edge of Chicago's famed and pungent stockyards, the 10,980 registrants found ample room for exhibits and for the general sessions but not quite enough, sometimes, for the round table sessions.

Those who had watched the Democratic convention on television a few weeks earlier were familiar with the arena, the huge hall used for the general sessions and the House of Delegates. But this vast stadium constitutes only a small percentage of the total area the International Amphitheatre contains. Nearly 450 commercial and educational exhibitors displayed and demonstrated their products or described their services. Of these, 414 were commercial exhibitors, making the largest "Hospital Merchandise Mart" ever staged.

Chicago rush-hour traffic being what it is, not all convention visitors found the International Amphitheatre quite as easy to get to from the hotels as, say, the Boardwalk convention hall in Atlantic City. The Association knew this would be true and in a concerted effort to make it as easy as possible chartered a fleet of buses to carry people, free, between the hotels and the hall. As in the regular workaday world, there were rush-hour traffic jams, eased after the first day by a sharp increase in the bus service.

In the House of Delegates, Tol Terrell, administrator of Shannon West Texas Memorial Hospital, San Angelo, Texas, was chosen president-elect, to take office a year from now during the 1957 convention in Atlantic City. Dr. Albert W. Snoke, director of Grace-New Haven Community Hospital, New Haven, Conn., was installed as president for 1956-57, succeeding Ray E. Brown, superintendent of the University of Chicago Clinics.

Also in the House, a major policy statement was adopted (see p. 73) recommending that member hospitals that are affected use the Blue Cross reimbursement formula, rather than billings, in providing hospital care to the dependents of uniformed servicemen.

This year marks the tenth anniversary of the Hill-Burton Hospital Survey and Construction program. Hill-Burton, through its stimulation of hospital planning and its technical and financial aid in construction has been probably the greatest single factor in the postwar hospital picture. At this convention, then, it was fitting that the sponsors of the original act, the two men for whom it was named, be honored. Lister Hill is still a United States senator, a Democrat from Alabama. Harold Burton, then a Republican senator from Ohio, now is an associate justice of the U. S. Supreme Court. Both came to the convention, were greeted with a standing ovation from the House of Delegates, and acknowledged with dignity the acclaim so rightly theirs. Each was presented with a certificate of appreciation from the Association. Other certificates were presented to the Department of Health, Education, and Welfare (Dr. Lowell Coggeshall accepted for Secretary Marion B. Folsom) and to the Public Health Service. Dr. Leroy E. Burney, surgeon general of the Public Health Service, accepted this certificate on behalf of his staff and the previous surgeons general who administered the Hill-Burton Act. A fifth certificate went to George Bugbee, president of the Health Information Foundation and former executive director of the American Hospital Association, for his leadership in the formulation of the program and his constant support of it.

Secretary Folsom himself appeared later in the convention and addressed an overflow crowd at the tenth annual luncheon of federal hospital executives. He described the present program and future plans of the Department of Health, Education, and Welfare, and expressed the opinion that the federal government will continue to support the reinsurance principle for voluntary health insurance coverage. His audience read like a "Who's Who" in both federal and civil health services.

The Future of Hospital Care

HOSPITAL ADMINISTRATORS, through experience and through education, have been conditioned to the inevitability of change and know the consequences of being caught unaware by the passage of time.

Last month in Chicago, several thousand hospital administrators got together and, by design, the conversation was focused upon tomorrow.

From the outset, the theme of the American Hospital Association's 58th annual convention was "Planning for the Future." Virtually everything on the program centered about that theme. Summed up, the pattern was something like this: *What are the needs? What are the resources? How do we use the resources to meet the needs?*

The answers to these questions cannot be summed up so succinctly. They must be weighed and evaluated in the light of local circumstances.

With such a theme, the audience naturally heard a great deal of discussion of the aged and their problems—problems of geriatrics, chronic illness, mental

illness, custodial care, rehabilitation, nursing homes, home care.

Certainly, the administrators came away from the convention with an acute awareness of the multitude of men and women over 65 who will inhabit our communities. Speaker after speaker emphasized the tremendous advances in longevity during the past half century, and the problems these elderly persons will create in terms of hospital care. More than once an administrator might have heard the earnest plea, "We have added years to their life; now let's add life to their years."

WHAT ARE THE NEEDS?

The keynote was sounded by Dr. Theodore G. Klumpp, whose service as chairman of the Hoover Commission's Task Force on Medical Services and his membership on the Commission on Chronic Illness certainly qualified him to comment on future needs in hospital care.

Assuming the present rate of population growth in the United States, about a quarter of a million persons every month, Dr. Klumpp projected the 1980 population at 238 million. This is an increase of about 70 million in just 24 years, an amount roughly equivalent to the combined 1950 populations of the eight most populous states. Our older persons, Dr. Klumpp said, are increasing in numbers at an even faster rate: By 1980 we can expect to have some 70 million persons 45 years of age or older, and of these, 25 million will be 65 or older.

Even today, according to informed estimates, there are some 28 million persons who can be considered chronically ill. And as might be expected, the older the individual, the more likely he is to be disabled. At the present time, Dr. Klumpp estimated two-fifths of the disabled are age 65 and over.

What adjustments, Dr. Klumpp asked, will hospitals have to make to fulfill their mission in the changing climate of medical care? Many hospitals have added rehabilitation services as a major step toward broadening the hospital's mission. "But the hospital is still only a repair shop," Dr. Klumpp asserted, "where broken bodies are sent to be mended. Some day it will also be a maintenance shop where the most intricate mechanism in the world will be sent to find out how it can be better cared for to prevent damage.

"This is, in my opinion," he added, "the most significant change in function, or mission if you will, that faces the hospitals of the future."

This does not mean that the general hospital should necessarily house all these services and functions under one roof. "On the contrary," Dr. Klumpp emphasized, "in some communities there could be distinct advantages in a multiple unit institution. Indeed, one of the important considerations in this idea is to move patients from the more costly operating units to others where the square foot building costs, overhead and maintenance are less." The important point: Services and functions should be administratively integrated to facilitate the shift of patients from one service to another with a minimum of delay, cost, motion and red tape.

What about financing this type of hospital service? Dr. Klumpp believes the first step is to convince the public that a hospital is not a hotel, and why it is more costly to operate. The second step, he said, is to stimulate the public to budget the cost of hospital and medical care more completely and extensively through insurance.

MENTAL HEALTH NEEDS

Dr. Jack R. Ewalt, director of the Joint Commission on Mental Illness and Health, cited some well known statistics—and some not so well known. Most people by now have heard that more than half of the hospital beds in the United States are devoted to the care of the mentally ill, and that these beds handle only about two and a half to three per cent of the total persons annually admitted to all hospitals. Fewer people know, he said, that almost as many patients are admitted to general hospitals for psychiatric problems as go into the regularly organized mental hospitals. Many of these are assigned to general medical beds and not to neuropsychiatric units.

The Joint Commission on Mental Illness and Health has designed a three-year study of the mental health practices and needs in the United States. This study, as Dr. Ewalt described it, will result in a tremendous store of knowledge of the mental health problem of today and the problem we will face in the future.

WHERE ARE THE RESOURCES?

Identifying the need is but the first step in solving a problem. Next comes a search for resources to meet that need. In the case of hospital care, those resources are not financial alone. For hospital care is personal care, and even where mechanization is put to its fullest use in hospitals, no substitute has been found for the judgment and the tenderness of the human being. Money alone will not guarantee a hospital the personnel it needs, for many of those persons are highly skilled professionals, technicians with years of training, purchasable only at the rate of 12 months to the year, not merely 100 cents to the dollar.

Yet dollars are important, for they can buy brick and mortar, they can buy equipment and supplies, they can buy effective utilization of the skills which are available.

Ten years ago, the federal government, with the active support of the American Hospital Association, launched a multi-million dollar program of grants in aid for the planning and construction of voluntary hospitals. This program, the Hill-Burton Hospital Survey and Construction Act, has been endorsed and strengthened, over the past decade, by leaders of both political parties, who see it as a shining example of a method whereby the federal government and nongovernmental agencies can work together harmoniously. The framers of the act, and those who administer it, have come up with what is generally considered the best method yet devised for government financing without government control.

At last month's convention, Dr. Lowell T. Coggeshall pointed to the Hill-Burton Act and its broadening amendments as a potent resource for meeting future needs. Dr. Coggeshall, dean of the Division of Biological Sciences at the University of Chicago, now is serving as special assistant for health and medical

THE ONLY father and son team to serve together in the AHA's House of Delegates consists of (left) Jack A. L. Hahn, administrator of Methodist Hospital, Indianapolis, and his father, Albert G. Hahn, administrator of Protestant Deaconess Hospital, Evansville, Ind. The elder Mr. Hahn is also executive director of the Tri-State Hospital Assembly.

affairs to the secretary of the U. S. Department of Health, Education, and Welfare. In that capacity, he is closely associated with the administration of federal health programs by the Public Health Service. One of these is a program of research grants. The American Hospital Association is now participating in this research program, and one Association project, for which a federal grant was made, is a study of the nation's future needs for hospital facilities.

Under the expanded Hill-Burton program, as described by Dr. Coggeshall, new emphasis is being placed upon rehabilitation facilities and community centers for diagnosis and treatment, and on nursing homes and chronic disease hospitals. "These newer types of facilities," he said, "are one device to take the pressure off general hospitals."

Dr. Coggeshall made a plea for better utilization of the resources we now have. "More thought must be given to rational distribution of expensive personnel with patients grouped in facilities according to the degree of their illness," he asserted. "We must use more imagination in designing hospitals and organizing their services to fit patients' needs. At present we assume that everyone who is admitted as an inpatient is acutely ill, requiring complete nursing service, complete laboratory service, and complete housekeeping service, as well as medical care. This assumption is one of the many reasons why costs of building and operating hospitals have been going up so fast. Bedside nursing care and bedside food service are large items in operating costs."

Dr. Coggeshall made this plea: "In planning future health services for every American, let us turn aside from the obvious if it offers no promise. Let us break with tradition if necessary. Let us use our native ingenuity and persistence to the utmost."

One man who might have said "amen" to this was George Bugbee former AHA executive director who now is president of the Health Information Foundation, which also finances research projects in the field of health.

Mr. Bugbee told his audience that while the financial problems of hospitals are great, they cannot be called critical in the sense that most hospitals are on the verge of closing because of budgets which cannot be balanced.

"Hospital service—adequate or meager—is provided in proportion to the funds available from patient income or public and private charity," Mr. Bugbee said. "Thus," he continued, "*meager funds mean meager care*, and budgets for all hospitals are, over a period of time, forced to balance."

More fundamentally, he asked, "does this mandatory equation between income and outgo allow hospitals to provide all of the care which is needed by the public?" Probably, he said, the answer is "no." He elaborated: "We certainly can visualize much that hospitals should be doing in providing better care if we are fully to meet the public need for service and to accomplish the lifesaving procedures which can come on the basis of present scientific knowledge. No one knows this better than the hospital budget balancer because he faces the reality that his balance is attained at the expense of limiting certain services which at least for some patient may mean the difference between success and failure in medical care, or—at least—may limit the care which might spell less frightening experience or provide a better climate for recovery."

While recognizing that the public is already critical of hospital costs, Mr. Bugbee expressed his opinion that "people are more understanding than the budget balancers believe."

The former AHA executive director looked to prepayment plans as resources for meeting future needs. Through prepayment, health care can be financed by the individual, and the providers of that care are assured payment. But the prepayment plans have a long way to go, Mr. Bugbee said. They do not cover a large enough percentage of the total of medical care costs. "Presently," he explained, "the usual type of voluntary health insurance, as provided by Blue Cross or Blue Shield or insurance companies, is written to cover at most a portion of the care in general hospitals. But hospital care represents only about 20 per cent of family expenditures for medical care." He cited home and office medical care, the cost of drugs, appliances and dental care, as health expenses not normally covered by prepayment plans. He compared this to the sale of an automobile if only the engine or body of the car could be sold on an installment basis while the customer had to pay cash on the line for the rest of the vehicle.

UTILIZING RESOURCES

The resources for meeting hospital needs can be divided into four general types: Community resources, contributed services, industrial resources, and the resource of knowledge. Each fell into place.

Community resources: Harrison M. Sayre, president of the Columbus (Ohio) Hospital Federation and a member of the Franklin County (Ohio) Regional Planning Commission, told how community resources in the Columbus area were put to use in improving hospital services. It began a dozen years ago, when a survey was made of the hospital situation in Greater Columbus. The late Dr. Fred Carter of Cleveland, a past president of the AHA, recommended, among other things, that a strong hospital council be formed, including all hospitals of the county, in the interest of unity, sound planning and higher standards. Such a council was formed, and it has given substance and continuity to subsequent efforts to coordinate and improve hospital services. Another recommendation

of Dr. Carter was that efforts be made to enlarge and upgrade the hospital and medical school of Ohio State University, situated in Columbus, to create a great medical center for the state. This point, Mr. Sayre pointed out, also is well on its way toward fulfillment.

A third recommendation of Dr. Carter has been that the number of acceptable general hospital beds in the county be doubled, to achieve a bed ratio of 3.5 per thousand population. This, Mr. Sayre said, has not been easy to achieve. It has been complicated by a rapid population growth, which creates new bed needs faster than they can be met.

A new survey was made in 1954—ten years after Dr. Carter's study—and it confirmed all suspicions that a tremendous building program was needed if the area's hospital needs were to be met. More than 25 million dollars were needed—far more than could be raised quickly by voluntary gifts in a city of 600,000.

This 1954 survey had been a cooperative undertaking, Mr. Sayre said, sparked by the hospital council but embracing representatives of business and industrial leadership as well as the hospital boards. These business and industrial leaders and hospital trustees concluded that the only way so much money could be raised was through taxation. But this required permissive legislation not on the books.

"We discovered that seven hospitals in Ohio which had been erected by city or county funds were subsequently leased for operation by voluntary nonprofit associations," Mr. Sayre said. "What we needed and got was permission, with approval of the voters, to erect such buildings, or hospital wings, for the express purpose of leasing them, at a nominal sum for a 50-year term, with privilege of repurchase at depreciated values."

A description of this new Ohio law and how it works appeared in the September 16 issue of HOSPITALS, J.A.H.A.

Contributed services: As voluntary institutions with altruistic motives, hospitals attract service-minded volunteers who want to do what they can to help the patient.

J. Stewart Baker, president of the Chase Manhattan Bank and president of the board of trustees of St. Luke's Hospital, New York City, questioned whether hospitals are taking full advantage of this great volunteer market. These people offer their services as members of auxiliaries, as members of religious orders, as working volunteers, or as trustees, all without pay.

Last year in New York City, he reported, more than 11,000 volunteers contributed two million hours of work in medical social service, nursing, occupational therapy, recreational therapy, patients' libraries, laboratories, linens and supplies, gift shops, sewing, and translation. The range of volunteer services, he emphasized, is tremendous.

Mr. Baker listed two broad areas in which active volunteer service can be sought:

(1) Volunteers should be used to supplement and support the activities of the regular staff in a way that will release scarce professional personnel from time-consuming nonprofessional duties.

(2) Volunteers can contribute their services effectively in the development of certain extras, such as services and projects of benefit to staff, patients, and visitors which under other circumstances would not be launched because of limitations of personnel and budget. Examples are gift shops, coffee shops and babies' alumni projects.

Industrial resources: It is well known among hospital people that business and industry have largely replaced the individual benefactors in the matter of finance. But an industrialist told the convention last month that "business and industry have too often been used only as a source of funds, a pocket book, a means to fill the hospital coffers; but seldom has it been chosen as a partner to help plan; to extend to the hospital its resources of organization and management techniques."

The speaker was Nathan J. Stark, vice president of the Rival Manufacturing Company and a board member of the Kansas City Area Hospital Association.

"Industry has been particularly critical of the patently trumped-up claims of some hospital expansion programs," he cautioned his audience. "Coming on the heels of one another, different appeals quote widely divergent figures to demonstrate their shortage, in reality making it very easy to compare and conclude that something is wrong with the figures and the claims obviously spurious.

Mr. Stark said business and industry have at least three broad and deep concerns in the hospital field: (1) Assurance of good facilities for employees; (2) the desire that these services be provided as inexpensively as possible, and (3) a desire for economy in expansion programs, since they are often called upon to meet a major portion of the expenditure.

The point Mr. Stark was making: While business and industry are willing to do their share in providing *dollars* to improve or expand hospital services, they can and want to provide something more—participation, leadership perhaps, a contribution of business talents and industrial experience toward the solution of hospital problems. Business and industry have so much to offer the hospital that it is wasteful to ask for dollars while ignoring the potentially greater contributions of know-how.

The resource of knowledge: One of the resources which money alone will not buy is knowledge. Alan E. Treloar, Ph.D., director of research for the American Hospital Association, explained some of the difficulties about using it.

"In 'utilizing the resource of knowledge,' we must first be free of doubt about our knowledge," he cautioned. "We see that ours is hazy, our communication of it poor, our dependency on other sources great. These attributes of our knowledge suggest a conclusion which to some is obvious: We are dealin with a new subject."

Mr. Treloar reminded his audience that formal e ucation for hospital administration is relatively r . The first attempt to establish a course in hospital administration was made as recently as 1930, he said, and the first such course to endure was inaugurated at the University of Chicago in 1934. "Consider that concerted effort for licensing of hospitals occurred in the last decade. Reflect that one of the first major attempts at definitions was made only three years

ago at the Hospital Classifications Conference held under the auspices of the American Hospital Association. Remember, consider, and reflect—and we may be proud that we have moved far in so short a time. We have gone through our infancy and our childhood. We are now in the age of adolescence, and all with teen-age offspring know what a trying period now confronts us."

Defining terms, a simple-sounding job, becomes almost hopelessly complex. Mr. Treloar confessed that one of his research groups has come up with 62 different definitions of the word "hospital." And the attempt to define a hospital continues. Similar problems come up with "convalescence," "basic room charge," and "chronic illness."

But he was optimistic: "We await our Aristotles and our Newtons. The threshold of a great advance is before us. We must question, we must search, we must not be afraid to venture upon new paths. But, most important, we must think in terms of patterns, not alone in the light of our own interests. We must see ourselves as part of the total, and judge our actions as they pertain to the whole field. Let the experts in the various specialties be aware of the problems in the others, and so make their demands that none will suffer or be relegated to the background. Let everyone in the hospital field act in this manner and our 'utilization of knowledge' will take care of itself."

MEETING THE NEEDS

With the needs defined and the resources explored, the final step is to put those resources to work in meeting the needs.

Concept of total care: While it may appear to the layman that problems of caring for the aged and the chronically ill should have little effect upon service to short-term acutely ill patients, there is really a very direct relationship. When short-term beds are tied up with long-term patients, a shortage of general hospital beds is created. A logical step then is to build more general beds to alleviate this shortage. Why not, instead or in addition, take steps to get the long-term patients out of the short-term beds? Admittedly, the best way to do that is to make the long-term patients well and send them home. But it is not that simple. First of all, many can never get well again. And if they did, some have no homes to go to. And some are not actually sick but merely require some form of custodial care.

Dr. Howard A. Rusk discussed all this and placed emphasis upon what he termed "insufficient provision for the care of custodial patients who no longer require hospitalization but who are nonetheless unable to be discharged, and are therefore accumulating in the hospitals."

A recently completed survey in New York City's municipal hospital system indicated that more than 19 per cent of the patients in those hospitals no longer required hospital care but could not be discharged because there was no place to send them. Dr. Rusk, chairman of the Department of Physical Medicine and Rehabilitation at New York University-Bellevue Medical Center, emphasized that this survey did not include hospitals or wards devoted exclusively to tuberculosis, mental disease, maternity and newborn care.

It is for the patients who no longer need hospital care but cannot be discharged for lack of other facilities, that new concepts of total care must be developed, Dr. Rusk said.

For those patients who can be discharged and who have a place to go, a home care program seems to be the answer. For those who could be discharged but have no place to go the problem is more difficult. Sometimes the right kind of nursing or boarding home provides the answer. But there is a need for something better, something more home-like, an institution to render high quality nursing care in a noninstitutional atmosphere. In New York they are talking about such institutions and have tentatively named them "homesteads." Under the supervision of a few registered nurses they would be staffed with carefully selected and specially trained practical nurses, voluntarily enlisted from the ranks of emotionally stable middle-aged women.

These "homesteads," he said, should be near medical facilities to which patients could be transferred quickly in the event of acute illness.

Hub of rehabilitation: Because of the squeeze that long-term patients are putting upon short-term facilities, the hospital can and should become the center of rehabilitation activities in the community. This was the suggestion of Dr. Joseph N. Schaeffer, associate medical director of the Institute of Physical Medicine and Rehabilitation in Peoria, Ill. He said this could be done with very little additional cost. "First," he said, "the hospital can accept the fact that rehabilitation is economically sound." He estimated that 75 per cent of the patients referred to the rehabilitation center in Peoria could be successfully rehabilitated in community hospitals "with well trained nurses and one physical therapist plus intelligent use of community resources." For the chronically disabled who cannot be cared for in a community hospital, Dr. Schaeffer suggested comprehensive rehabilitation centers where the more complex problems can be referred.

Service to the aged: A recurring plea was heard at this convention, and it went something like this: In planning future facilities for caring for the long-term patient, the chronically ill, let us not repeat the mistake we made years ago in the field of mental illness by building these facilities far out in the country, isolated from the community and its general hospitals.

Dr. Leonard O. Bradley, administrator of the Winnipeg (Manitoba) General Hospital, called this practice an "out of sight, out of mind" answer.

He suggested that we begin with the provision of medical services to the aged person in good health. This group constitutes about 96 per cent of the aged, he said. For them, care should be provided in the regular established medical channels of the community. One problem here, Dr. Bradley told his audience, is the reluctance of the family doctor to treat the older person. The hospital outpatient department can serve a useful purpose for those who are ambulant and of limited resources.

The mental patient: With increasing knowledge about

(Text continued on page 70)

the convention the camera

We came to Chicago by train . . .

. . . and we came by plane.

First, we registered at our hotel . . .

. . . and then we caught a special bus to the International Amphitheatre . . .

. . . where we filled out convention registration cards . . .

through lens

. . . and got our badges . . . and pinned them on.

We studied the convention program . . .

. . . drank a soft drink . . .

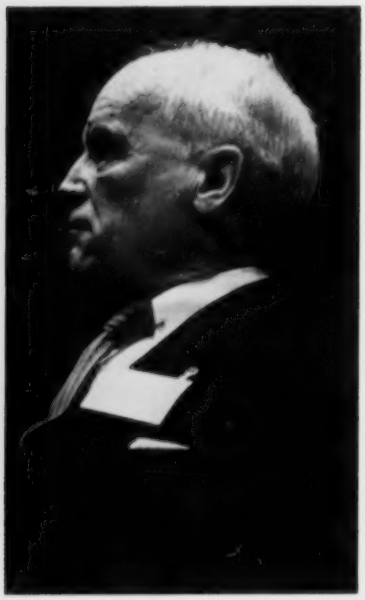
. . . and sipped coffee with friends.

The AHA Service Center answered our questions.

We watched the House of Delegates deliberate . . .

. . . and heard Senator Hill speak . . .

. . . while Justice Burton listened . . .



. . . and we gave a standing ovation to these two public servants—Hill and Burton.

Gus Hoenack of the Public Health Service was an interested spectator . . .

. . . as a panel discussed hospital planning.

We went through the receiving line at the president's reception.

The youngest "registrant" was curious . . .

At the round table sessions . . .

. . . the rooms bulged at the seams.

. . . and so were some older ones . . .

. . . about the thousands of products and services on display at the largest Hospital Merchandise Mart ever staged.

(Continued from page 65)

mental illness has come an awareness that some of our methods of the past have been exactly wrong. One of our society's worst sins has been that too often the blanket term "mentally ill" has been applied indiscriminately to a large number of persons who really do not fit that classification at all. Again, Mr. Treloar's concern with definitions.

Dr. Daniel Blain, medical director of the American Psychiatric Association, told the convention that his organization has described seven separate disorders which are listed in the Standard Nomenclature of Diseases and Operations published by the American Medical Association.

But confusion comes when any of the symptoms which may accompany a mental disorder is mistaken for the disorder itself, and the person is included in the ranks of mental patients. Man, being a complex animal, experiences deviations in his emotions.

"There is a place in a concept of normal and healthy living," Dr. Blain said, "which allows a person to be afraid sometimes, to be occasionally forgetful, to be confused, to be a little compulsive, to have a little disturbed sleep and even to be suspicious of someone without being labelled a mental patient . . . These symptoms are as natural as getting out of breath after climbing a hill, or fatigued by physical exertion or having a sore muscle from unwanted exercise, or losing our appetites when excited."

Having identified our patients and defined our terms, we must take steps to provide care for these patients. Bad as it was, the asylum that developed about 1800 was a great advance over the pest house, the dungeon, the poor house and the chains that preceded it. The change to hospitals was another great advance, but isolation and segregation were believed to be in the best interests of the patient. Lack of psychiatric technical advances was the most important reason for neglect of mental patients, in Dr. Blain's opinion.

The picture now looks brighter. New knowledge brings new concepts and new forms of treatment, often requiring new ideas in facilities.

Throughout all these discussions of the future of hospital care the thoughtful administrator could not help seeing his hospital in a new and expanded role. If the predictions of the speakers at the 58th convention come true, the general hospital of tomorrow will be a comprehensive treatment center not only for the acutely ill general medical and surgical patients but, either in the main building or in integrated units, for the long-term chronic disease patient and, the mental patient as well. The hospital will be a community health center, the focal point of all health activities in its area. It will be more truly an educational institution and a research laboratory. It will become more of a leader in community planning, and in turn it will more fully take the community into its confidence, using more effectively the skills, talents and vast resources that business, industry and the community have to offer. It will probably work more closely with local, state and national government than it has in the past, but if it keeps its own house in order and maintains a progressive, forward thinking attitude, it will not lose to government its prerogatives as a free voluntary institution.

Tol Terrell Is President-Elect

AMERICAN Hospital Association President-elect Tol Terrell (left) and AHA President Dr. Albert W. Snoke take time out from their busy convention schedules for some relaxing conversation.

THE BUSINESS OF electing officers, trustees and delegates-at-large of the American Hospital Association was completed at the final session of the AHA's House of Delegates on Wednesday morning (September 19).

In addition to naming Tol Terrell (see p. 71) president-elect, the House re-elected John N. Hatfield, treasurer of the Association. Mr. Hatfield, director of Passavant Memorial Hospital, Chicago, is a former AHA president (1949). He has also given the Association many years of service as a trustee and as a former chairman of the AHA's Council on Government Relations. Mr. Hatfield has served as Association treasurer since the summer of 1953, when he was named interim treasurer following the death of Dr. Arthur C. Bachmeyer. He was elected that fall to his first full term as treasurer at the AHA convention in San Francisco in September 1953.

MR. HATFIELD

The following four new members of the Association's 13-member Board of Trustees were also elected by the House of Delegates: Abbie E. Dunks, director of the Boston Dispensary; Dr. Edwin L. Harmon, director of Grasslands Hospital, Valhalla, N.Y.; Reid T. Holmes, administrator, North Carolina Baptist Hospital, Winston-Salem, N.C., and Raymond K. Swanson, superintendent, Swedish Hospital, Minneapolis.

Miss Dunks is a former president of the Massachusetts Hospital Association and a member of the governing board of the Hospital Council of Metropolitan Boston. A graduate of Simmons College in Boston, Miss Dunks is a fellow of the American College of Hospital Administrators.

Dr. Harmon is, like Miss Dunks, an ACHA fellow. In 1955 he was named to the Commission on Chronic Illness. He was graduated from the School of Medi-

MISS DUNKS

DR. HARMON

MR. HOLMES

MR. SWANSON

cine, Western Reserve University, Cleveland, in 1927.

Mr. Holmes is a former president of the North Carolina Hospital Association. He has served as chairman of the AHA's membership committee. In 1939, he received his bachelor of arts degree from Duke University.

Mr. Swanson was graduated from the University of Minnesota in 1921. He has been superintendent of Swedish Hospital in Minneapolis since 1943. A past president of the Minnesota Hospital Association, Mr. Swanson has also been president of the Upper Midwest Hospital Conference. He is a former vice chairman of the AHA's Council on Prepayment Plans and Hospital Reimbursement.

The following delegates-at-large of the AHA were also elected at the House's final session: Paul R. Hanson, administrator of Emanuel Hospital, Portland, Ore.; Carl C. Lamley, director of Stormont-Vail Hospital, Topeka, Kans.; Edwin B. Peel, administrator of Georgia Baptist Hospital, Atlanta; S. A. Ruskjer, administrator of Waverly Hills (Ky.) Tuberculosis Sanitarium, and Clarence E. Wonnacott, administrator of W. H. Groves Latter Day Saints Hospital, Salt Lake City, Utah.

NEW COUNCIL CHAIRMEN

Three new council chairmen were appointed by AHA President Dr. Albert W. Snoke and approved by the AHA's Board of Trustees at its September 19 meeting.

Mary C. Schabinger, R.N., was named chairman of the AHA's Council on Association Services. Miss Schabinger is superintendent of DeEtte Harrison Detwiler Memorial Hospital, Wauseon, Ohio.

MISS SCHABINGER

DR. WILSON

MRS. BLODGETT

Dr. David B. Wilson was named chairman of the AHA's Council on Hospital Planning and Plant Operation. Dr. Wilson, director of University Hospital, Jackson, Miss., received his doctor of medicine degree from Emory University, Atlanta.

Mrs. Frederick N. Blodgett was named chairman of the newest AHA council, the Council on Hospital Auxiliaries, formerly the Committee on Hospital Auxiliaries. (The name change was approved at this year's meeting of the House.) Mrs. Blodgett, a graduate of Vassar College, Poughkeepsie, N.Y., is a past president and member of the Ladies Committee, New England Medical Center, Boston.

Four Council chairmen were reappointed by President Snoke and approved by the Board of Trustees. They are:

Stanley A. Ferguson, director, University Hospitals of Cleveland, Council on Administrative Practice.

Dr. Lucius R. Wilson, director, Episcopal Hospital of Philadelphia, Council on Government Relations.

Edward K. Warren, chairman of the board, Greenwich (Conn.) Hospital Association, Council on Prepayment Plans and Hospital Reimbursement.

Dr. Russell A. Nelson, director, Johns Hopkins Hospital, Baltimore, Council on Professional Practice.

THE NEW PRESIDENT-ELECT

Tol Terrell, the new president-elect of the American Hospital Association, will become the AHA's 59th president when he succeeds Dr. Albert W. Snoke in September 1957. Dr. Snoke, director of Grace-New Haven (Conn.) Community Hospital, was installed as AHA president at the Association's annual banquet September 19.

A 40-year-old Texan who has been connected with Texas hospitals since his graduation from Austin College, Sherman, Tex., in 1937, Mr. Terrell began his career as administrator of Wilson N. Jones Hospital (72 beds), Sherman, serving that hospital from 1937 to 1939. From 1939 to 1948 he was administrator of Harris Hospital (328 beds), Fort Worth, Tex. In 1948 he assumed his present position as administrator of Shannon West Texas Memorial Hospital (144 beds).

Mr. Terrell was appointed to the AHA's Council on Professional Practice in 1955. He served from 1953 through 1955 on the Association's 13-member Board of Trustees. In 1955 he was chairman of the Board's

legislative committee. Mr. Terrell's state hospital association activities parallel his national achievements; he has been both president and trustee of the Texas Hospital Association. A regent of the American College of Hospital Administrators, he also holds a charter membership in the Texas Association of Hospital Accountants. He has been a trustee of Group Hospital Service, Inc. (Blue Cross), and Group Medical and Surgical Service of Texas (Blue Shield) since 1943. He has also been a trustee of the American Protestant Hospital Association.

Mr. Terrell and his wife "Chick" have four children: a 15-year old daughter, 11-year old twins (boy and girl), and 18-year old Charles, 225 pound high school football star, who enrolled at Southern Methodist University accompanied by his parents on their way to the AHA convention in Chicago.

A dove hunter who regrets that his new responsibilities may cause him to miss much of his favorite sport (it's the height of the season now in the prairies around San Angelo) he hopes, however, to be able to keep a fatherly eye on the fortunes of the SMU football team in the next few years.

Shannon West Texas Memorial Hospital, better known by its shortcut name, Shannon Memorial, is a 144-bed community hospital serving acute and general patients in San Angelo, Tex. The largest hospital in San Angelo, Shannon Memorial also helps care for some 250,000 people in the vast rural area surrounding the city.

The hospital, established in 1932, was provided for in a trust created by the will of Mrs. J. M. Shannon of San Angelo. The trust specified that the hospital would be free to those who were not able to pay. Those who were able to pay were to be subject to reasonable charges determined by the board of trustees (currently a 7-man group). The hospital admitted 5,690 patients in 1955 and had an average daily census of 107.

The hospital's physical plant has undergone five building and remodeling programs. The most recent, involving the renovation of the dietary department, was completed in 1955. The building was completely air conditioned in 1937. A 100-bed addition consisting of private rooms is now in the planning stage.

Shannon Memorial has a 3-year nursing course operated in affiliation with San Angelo Junior College. The course leads to an associate of arts degree.

House of Delegates at Work

A WASHINGTON-ESTABLISHED POLICY on the handling of the hospital care program for the dependents of uniformed servicemen gave the Association's House of Delegates its toughest 1956 item for debate and decision.

But the reaffirmation of the Association's principle of support of Blue Cross and its prepayment methods as the logical and most economical vehicle for the handling of the dependents' program was only one of the items the House had on its agenda. (This one developed unexpectedly because the government decision on the matter was made only a few weeks ago.)

The House also: voted several bylaw changes; heard a detailed explanation of how rising costs had forced a cutback in the Association's building program; approved an organized and formal campaign for voluntary donations to the building fund; approved a policy statement on hospital and medical care for veterans, adopted a guide for hospital rate setting and a statement on hospital-employee relations.

The House began its consideration of the servicemen's dependents issue by listening to Army Lieut. Col. D. C. Buchanan, a member of a Defense Department task force. The task force was assigned the task of designing a program to put into action the law voted by the last Congress giving medical and hospital care benefits to some 800,000 dependents of servicemen. The program goes into effect December 8.

He explained the Defense Department's insistence on a plan, based on the service benefit concept, which was uniform, complete as to inpatient care (certain outpatient benefits are allowed in the military hospitals), adequate as to standards, practical as to costs and administration, and accessible to all.

Colonel Buchanan explained that the government would pay the bill but would select an agent or agents to be its administrative representative. State medical associations, he explained, had been permitted to express preference as to the fiscal agent for the medical care aspects. It was pointed out later that such a privilege had not been granted to state hospital associations but that 46 state associations had requested such a right of preference and also indicated that their preference was Blue Cross rather than commercial insurance.

Then Colonel Buchanan touched on the point which touched off the debate. He said the Washington policy makers had decided that the government should "give a portion of the business" to both Blue Cross and to commercial insurance companies.

He flashed a slide on a screen in the darkened House. It showed the country split into three broad bands. The western band was blue. So was the eastern band. The middle swath was not. The west and the east would be administered by Blue Cross, he said, the midlands by commercial insurance companies. The exact distribution was not final, he told the House.

President Brown took the podium. He traced the development of the program and the Association's activities. He said that the Association had won a major victory by persuading Congress that the dependents should have access to voluntary hospitals for the government-financed care.

"We went all out for letting Blue Cross do the total job because of the benefits that would have brought to the program," he said. "There is only one method of prepayment which has built-in controls—Blue Cross and its contracts with hospitals. These controls are just not present with commercial insurance companies."

President Brown told the House that the issue which the Board was taking to the Delegates was this:

Shall the Association recommend to its members in those areas assigned to Blue Cross that they work out a reimbursement program for dependents based on the Blue Cross contract methods or should they demand full billings, the method which will neces-

sarily prevail in areas assigned to the commercial companies.

He said that in his opinion it was "very bad judgment" to split the country because it would cost the government an opportunity to save money. He also cautioned the delegates that there was a precedent involved. Although a relatively few small numbers are concerned in the dependents' program, the pattern set could be used for federal employees and other groups for which government takes prepayment responsibility.

He said that there was some opportunity to prove once the program was under way that Blue Cross was the right way to do it but he underlined the pitfalls and problems involved in making such a case.

He said he would expect some hospitals to react to any proposal that they should get less money than their colleagues in "commercial" states with a demand to know why should they be subsidizing this program.

On the other hand, he said, hospitals which created Blue Cross as a social agency, a service agency, perhaps should prove that they mean what they preach. Also, he said, "we have said that government should pay costs but no more."

The meeting was adjourned at this point until the final day, September 19. The House, which had been meeting in the Arena, gathered in the richly-panelled and portrait-bedecked ballroom of the Stock Yard Inn.

The Delegates wasted no time in attacking the decision to split the nation. Delegate-at-Large John Rankin of Milwaukee led off with the charge that the government knows this decision will cost it more money. "Therefore," he said, "the only conclusion we can draw on present information is that the decision was made purely for political expediency in an election year. . . . The AHA should inform the public that a serious error in judgment has been made."

Delegate F. O. McVey (New Mexico) said that it was more practical "to go for billings in the Blue Cross areas." He argued that hospitals everywhere were entitled to the same treatment.

President Brown commented that "in my opinion, the division is purely politics. Someone in the administration passed the word down that the insurance companies must get some business."

At the suggestion of Delegate Alfred Maffly (California), the Board of Trustees proposed a resolution for the Delegates' consideration. Because it was the last day, this was the only method in which new business could be brought to the floor without unanimous consent.

After it had been read, Delegate John Hay (Pennsylvania) offered an amendment to delete from the resolution a key section, Section 3 (see text below). This was argued and was defeated by a show of hands. Five hands were raised for the amendment.

The resolution itself was put to a vote and carried with four dissents. This is the text:

WHEREAS, the Board of Trustees of the American Hospital Association recognizes that this association has taken every reasonable and responsible action that it can to cause the development and enactment of legislation which will provide a necessary program of health care for civilian dependents utilizing civilian hospitals and civilian personnel and

WHEREAS, the significance of the enactment of a health care program for the dependents of uniformed servicemen has created a relationship between the federal government and the civilian hospitals which goes far beyond the immediate considerations of providing health care to such dependents, and

WHEREAS, the long range application of this program makes unnecessary the expansion of the federal hospital system to care for these civilian dependents; and

WHEREAS, the dependents of uniformed service personnel are basically an integral part of this nation's general civilian population receiving, to a great degree, their hospital care in our civilian hospitals, and

WHEREAS, Blue Cross Plans established by the civilian hospitals of this nation represent a social movement to assist in financing the health needs of the entire community; and

WHEREAS, Blue Cross Plans, through their contractual relationships with hospitals are able to administer a program of hospital care for dependents of uniformed service personnel on the most economical and efficient basis;

THEREFORE, BE IT RESOLVED That the Board of Trustees recommends to the House of Delegates the following action:

(1) that all member hospitals support Blue Cross Plans in aggressively seeking to undertake to administer the health care program for dependents of service personnel in all states where the Department of Defense indicates that Blue Cross shall be the administrative agent;

(2) that Blue Cross Plans, acting through the Blue Cross Commission, should designate a single agent to act for them at a national level to administer this program;

(3) that in all states where Blue Cross is designated as the Defense Department's administrative agent in the health care program for dependents of uniformed service personnel, that member hospitals accept the Blue Cross reimbursement formula in effect in each state or area at the time the Blue Cross services are provided.

(4) that for the first year's operation of the health care program for servicemen's dependents, the American Hospital Association, jointly with the Blue Cross Commission, undertake a continuing statistical study of comparative rates of payment in states where Blue Cross is designated as administrative agent, and in those states where the commercial insurance companies are designated as administrative agent; and that the member hospitals of this Association cooperate to the fullest extent to make such an analysis possible.

The House then went on to a matter on which the Delegates unanimously agreed: the election of officers.

The bylaw changes provided that the Committee on Hospital Auxiliaries become a council, thereby losing the seat in the House its chairman previously held; give the Board the right to reduce membership dues for students in hospital administration, and call the Association's highest honor, the Distinguished Service Award.

John N. Hatfield, of Chicago, Association treasurer and chairman of the Committee on Headquarters Building, told the Delegates of the building cutback forced by rising costs. He said the building would now be of seven stories (sufficient to house the AHA but not the allied groups) rather than 19 stories (17 above ground) as originally planned.

Immediately after Mr. Hatfield's report, Stuart K. Hummel, of Milwaukee, a council chairman and thus entitled to the floor, proposed an organized and formal campaign of voluntary donations to the AHA build-

ing fund. He said it was not possible to measure in dollars the benefits AHA members received and told the House that the finance committee chairman at the hospital he administers was willing to recommend a donation of $3,000. The resolution was moved from the floor and adopted.

The statement on veterans was published in HOSPITALS, J.A.H.A., March 16, 1956.

Hospital-Professional Relations

No convention would be complete, it seems, without at least one session on hospital-physician relationships. At this convention, the topic was somewhat broader and dealt with the hospital's relations with all professionals. But through it all, it was still the hospital's relationships with physicians, and more specifically with the so-called institutional specialists, that captured the limelight. These institutional specialists are the radiologists, the pathologists, the anesthesiologists and the physiatrists, the doctors whose specialties prevent them from having a normal medical practice with the usual doctor-patient relationship. These specialists are largely dependent upon hospitals for all their work, and in many instances they work for hospitals and receive a salary.

Some members of the medical profession argue that when the hospital pays the physician a salary, then the hospital is itself practicing medicine. This, they say, is unethical and sometimes illegal. Further, they say, the doctor who works for a salary is himself being unethical.

Hospital spokesmen maintain that only an individual can practice medicine and that regardless of the type of reimbursement to the doctor, the hospital cannot, does not and does not wish to practice medicine. For support, they point to the medical viewpoint that it is quite all right for the same doctor to perform the same functions providing he receives, instead of a salary, a commission or a fee from the patient or some other type of remuneration.

Prepayment plans also come into this picture. Blue Cross, for instance, reimburses hospitals for hospital services rendered Blue Cross patients. Is anesthesia a hospital service, reimbursable by Blue Cross?

Dr. Dwight H. Murray, of Napa, Calif., the president of the American Medical Association, presented the doctors' side of this picture. He asserted that medical opposition to the actual employment "and/or exploitation of physicians by hospitals" does not rest on a financial or an economic basis. "We are not opposing this encroachment just to be in opposition," he said. "Our purpose is to maintain the proper physician-patient relationship which is so sacred and traditional, and to retain the necessary professional freedom which is so inherent in the practice of medicine in the United States."

Dr. Murray acknowledged that "the best, long-lasting solutions come at the local level, with complaints being considered and ironed out within the hospital at the staff level." Traditionally, he said, physicians and hospital administrators have been able to settle their controversies successfully and equitably in meetings and conferences. "Intraprofessional disputes do not lend themselves readily to judicial determination," he said.

In a reference to a recent court decision upholding the doctors' position in Iowa, the president of the AMA said, "I sincerely believe that litigation and legislation should not be necessary to deal with the internal differences that arise between men who have proved by their achievements that they are dedicated members of the medical care team. I hope that we will not in the future use the courts to resolve our differences."

Ray E. Brown, who had finished his term as AHA president the previous day, related the picture as he sees it.

"If one examines closely the differences that have arisen between hospitals and physicians during the emergence of the modern hospital," Mr. Brown said, "it seems apparent that those differences are superficial to the basic issues which underlie the relationship.

"Most of the differences can be related to two issues. One of these has to do with the insecurity of the physician who must now depend upon facilities he does not own and upon personnel he does not employ. Modern medicine has removed his self-sufficiency and made his career and reputation dependent upon the right of hospital privileges. The second issue is the physician's fear of any circumstances that might restrict his right to professional freedom in the practice of his profession. Both of these issues are legitimate and must have first attention if the differences which grow out of them are to be fully resolved."

The American Hospital Association past president said that the failure to stick with the basic issues had not only produced unnecessary frictions but had handicapped important developments in the health field, such as prepayment coverage, medical education and hospital accreditation.

President Albert W. Snoke, M.D., of the American Hospital Association, added some comments of his own. He said it was not correct to assume that hospital boards and administrators are trying to control the practice of medicine or telling the physician how to care for his patients. "What we are trying to do," Dr. Snoke said, "is to provide an environment and an organization with the proper standards and policies to give the patient the best possible care."

Hospitals, he asserted, are just as deeply concerned as are physicians about patient welfare. Sometimes, he said, the subjects of ethics and economics get mixed up. "It makes little difference to the personal relationship between physician and patient," he elaborated, "if the patient receives a bill directly from the physician or from a business office of a hospital for some services."

Relationships of the hospital with other professional groups were covered by other speakers. Ruth M. Sleeper, R.N., director of the School of Nursing and Nursing Service at Massachusetts General Hospital, Boston, talked from the nurse's viewpoint. Two speakers represented the nonprofit prepayment plans, which have a vital interest in harmonious relations within the hospital. William S. McNary, a trustee of

the American Hospital Association and executive director of Michigan Hospital Service, Detroit, spoke for Blue Cross. Speaking for Blue Shield was Dr. Norman A. Welch, chairman of the Blue Shield Commission, Boston.

The Auxiliaries Become a Council

HOSPITAL AUXILIARIES left the Ninth Annual Conference in Chicago, September 17-20, wearing a "new look."

Since its formal organization as an AHA activity in September 1949, the auxiliary movement has been a committee of the Association. Without dissent, the House of Delegates at its 1956 meeting passed bylaws which gave the Committee the rank of a council of the Association, one of seven such councils. This action was taken at the first meeting of the House, on Sept. 17, so from the moment the 1956 conference opened, the registrants wore their "forward look."

Mrs. Frederick N. Blodgett, of the Ladies Committee, New England Medical Center, Boston, was named chairman of the new AHA council, succeeding Mrs. Cecil D. Snyder, of the Kenosha (Wis.) Hospital Auxiliary, who had served as chairman when the auxiliaries were a committee.

Dr. Albert W. Snoke, AHA president, stressed that auxiliaries must be considered an integral part of the hospital team. While gifts shops and snack bars once were considered the primary functions of "ladies" groups, they are now being shoved into the background as auxiliaries are learning to accept a greater responsibility in the care and comfort of patients and in bettering relationships between the hospital and community.

Because medical research has conquered most infectious diseases, doctors and hospitals now are working on answers to degenerative illnesses such as cancer and heart disease. Research takes money for new equipment, training of scientists and building additions to hospital facilities. According to Dr. James A. Shannon, director of the National Institutes of Health, Public Health Service, Congress allocated $90,000,000 for medical research in 1956 compared with only $1,000,000 10 years ago. But this is only a fraction of the amount needed, and much of the rest must be supplied from voluntary sources.

For example, the Raymond Blank Memorial Hospital Guild of Des Moines, Iowa, raised more than $9,000 for heart diagnosis equipment and sent two pediatric residents for special training in its usage. The guild won first prize for projects "Best Serving the Community Through the Hospital" for institutions with 101 to 300 beds. The entry of the Women's Auxiliary of the Pioneers Memorial Hospital of Brawley, Calif., was judged best among projects submitted by hospitals with less than 100 beds. The auxiliary took part in the civil defense and disaster plans of the hospital during a community-wide mock disaster drill.

Since charity begins at home, F. Ross Porter, superintendent of Duke Hospital, Durham, N.C., asked the delegates to build up Auxiliary-hospital relations. He said that doctors and administrators should not take services of volunteers for granted and that the groups should not step on each other's feet.

"Administrators and doctors and auxiliaries should cultivate each other," Mr. Porter said. "Each should take interest in and supplement the other's activities and follow regular hospital channels in working together."

Mr. Porter's advice was echoed by John Bigelow, executive secretary of the Washington State Hospital Association. He said auxiliaries were top-notch groups for building hospital-community relations. The hospital administrator and trustees must recognize, he said, that the auxiliary can build community relations and must give them a chance to do so. He reminded the auxiliary members that they must be close enough to the hospital to know what it is doing and to feel the motive of service so that they can impart it to others in the community.

The registrants sat in on a mock board meeting which planned services to be provided by an auxiliary.

They also aired their views and problems during a series of round tables. Subjects included directing large and small hospital volunteer corps, organizing a new volunteer service for the small hospital, teenage and junior volunteers and auxiliary organization in mental hospitals.

Dr. Daniel Blain, medical director of the American Psychiatric Association and a conference speaker, traced the history of mental hospitals in the United States.

The women also discussed how to make their meetings more effective by using audio-visual aids and how to organize a new volunteer service.

A plea for better auxiliary leadership was made by Mrs. J. Beaudoin Handfield, public relations director of the National Council of Hospital Auxiliaries of Canada. Mrs. Handfield said many a good volunteer was lost because she had a reputation of being "shy or not really interested," so she urged that some of these and other women be sent to leadership school since they often turn out to be the most eager and efficient workers.

The Rev. Granger Westberg, director of chaplaincy services and associate professor of religion and health at the University of Chicago, reminded delegates that the human side of hospital care which doctors do not have the time to give is often as important as medical attention.

This, Reverend Westberg said, is the duty of the chaplains and auxiliary volunteers in the hospital.

Besides project, organizational ideas and technical knowledge which the 1,000 registrants took home to their auxiliaries, they examined streamlined hospital equipment exhibited during the conference and were guests of the Chicago Children's Memorial Hospital, Grant Hospital, the University of Chicago Clinics, the Veterans Administration Research Hospital and the Merchandise Mart.

Allied Organizations Meet

ADMINISTRATION, MORE than any other calling, requires the individual to form a unity and balance of his own life and to deal in a strategic and tactical

manner with a greater body of knowledge than anyone else in the community.

This was the theme of this year's annual Bachmeyer memorial address, delivered at the meeting of the American College of Hospital Administrators by Marshall E. Dimock, Ph.D., head of the department of government at New York University.

Giving his conception of what it means to be an administrator, Mr. Dimock said times have changed since the Victorian Age, when administration was thought of as a humdrum affair, something that anyone with reasonable ability and perseverence could learn quickly.

At a convocation ceremony the College conferred fellowships upon 83 hospital administrators. Members approved the plan of the College to publish an educational journal.

Echoing the concern expressed by AHA convention speakers over the rapidly growing ratio of elderly persons in the population, the American Association of Hospital Planners devoted one session of its eighth annual meeting to a discussion of problems of operating a nursing home.

The proprietary nursing home was upheld as superior to its publicly-owned counterpart by Bert Cohn, operator of homes in Okawville and Benton, Ill.

The American Association of Hospital Consultants, whose aims are often closely connected with those of the hospital planners, were concerned this year with trends in hospital practices. At one session, Dr. Anthony J. J. Rourke of New York City discussed the value of the medical audit, remarking that the real function of the audit should be to improve the medical staff—not to intimidate it.

The consultants also considered a plan incorporating central supply "substations," the functions of which would be similar to those of stations operating before the concept of central supply came into being. With the substation system, sterilization would still be done centrally, but extensive supplies would be put in strategic areas with enough equipment to justify having someone in charge of the substation.

The hospital consultants and planners turned their collective attention to community and regional planning in a joint meeting that concluded both conventions. For this session a group of leaders representing nearly every phase of hospital planning and administration were assembled to give advice in planning future health care facilities for an actual community in southern United States.

Before any community can start planning for future health care facilities, thorough studies must be made of population growth and movement and of the degree of growth and diversification of industry, said Frank S. Groner Jr., administrator of Baptist Memorial Hospital in Memphis. Another basic, expressed by Aaron N. Kiff, a New York City architect, is that master planning incorporate the judgment of all hospitals and health organizations concerned.

Celebrating its 25th anniversary at its annual meeting, the American Association of Nurse Anesthetists reviewed progress made during the past quarter-century and charted its course for the future. Members approved a bylaw that only active members can be designated as certified registered nurse anesthetists and that an active member can purchase a life membership after 25 years of paying active membership dues. Another new bylaw provides that during the last six months of training, a student in a school of anesthesia approved by the association may apply for student membership.

Other Groups Elect Officers

SEVERAL ORGANIZATIONS in the hospital and health fields elected new officers at meetings held during the 58th annual American Hospital Association convention.

• The American College of Hospital Administrators named Frank S. Groner its president-elect. Mr. Groner is administrator of Baptist Memorial Hospital, Memphis, Tenn. He succeeds this year's president, A. J. Swanson, general superintendent, Toronto (Ont.) Western Hospital.

Anthony W. Eckert, director of Perth Amboy (N.J.) General Hospital, was elected first vice president of the College. Elmina Snow, administrator of Emerson Hospital, Concord, Mass., was named second vice president.

Two new members were also named to the College's Board of Regents: James Russell Clark, director of the Brooklyn (N.Y.) Hospital and R. Frazer Armstrong, superintendent, Kingston (Ont.) General Hospital.

Herbert D. Moe, chief, Hospital Facilities Section, Colorado Department of Health, was installed as president of the American Association for Hospital Planning.

• Dr. Jack Masur was re-elected president of the American Association of Hospital Consultants. Dr. Masur is assistant surgeon general and chief of the Bureau of Medical Services of the Public Health Service, Washington, D.C.

Jacque Norman, hospital consultant, Greenville, S.C., was named vice president of the group.

Dr. E. Dwight Barnett, director of the Columbia University, New York, School of Public Health and Administrative Medicine, was re-elected secretary-treasurer.

The membership also named Dr. Harvey Agnew, hospital consultant, Toronto, Ont., and Otis Auer, hospital consultant, Glen Ridge, N.Y., to the AAHC executive committee.

• The American Association of Nurse Anesthetists elected Lillian Baird, University Hospital, Ann Arbor, Mich., president. Olive Berger, The Johns Hopkins Hospital, Baltimore, was named first vice president and Evelyn Auld, Watts Hospital, Durham, N.C., was named second vice-president.

Marie McLaughlin, Dolton, Ill., was re-elected treasurer of the AANA.

The following were elected to membership on the board of trustees: (New England area) Alice Lamberson, Philadelphia; (Southern area) Lillian Stansfield, Winston-Salem, N.C., and (Tri-State area) J. Pauline Benefiel, Indianapolis. ■

your president reports

AMONG THE responsibilities of the president of the American Hospital Association is the writing of the president's page in **HOSPITALS** each month during his year in office. To write a column upon regular assignment is a new experience to me—I have previously written on specific subjects on my own volition rather than by command of the calendar—and I have never had to meet deadlines nor to limit the article by the size of the page. I asked Jim Hague and Dave Riddell what was expected of me in this report, and was gently but firmly told that the subject matter and the style are to be my own—they don't care what I say exactly, just so that it is brief and that I "get it to the church on time." I suspect that there is mild skepticism as to whether it is possible for me to be brief—I have been accused many times by my colleagues and my wife of being loquacious and verbose—but fortunately the size of the president's page will provide sufficient limitation to undue excursions.

I would like to use this president's page throughout the year to present informally, observations, experiences, and ideas that may result from my activities as president of this Association. It may be pertinent to raise questions or to seek opinions from the membership which may be of value in improving the service of the Association or in helping to provide better service to our patients.

From my experience as president-elect in the past year, it is obvious that an officer of the Association has a unique opportunity to learn so much more of the tremendously varied, complicated, and complex field of hospital administration as it exists in this country—as well as throughout the world—than he could in his own local hospital position. The vast majority of us in hospital administration base our judgments and decisions upon our local experience and environment. There are relatively few who have the opportunity of seeing and thus understanding clearly the different problems experienced by hospitals of large and small size; in rural, isolated and urban environments; existing under varying laws, economic levels, and with differing cultures, etc., etc. The American Hospital Association tries to meet this diversity of hospital problems through representative appointments to boards, councils, and committees. In addition, it is of value for as many individuals as possible to receive a broad and comprehensive education in this field. In line with this, the policy which has been developed over the past few years of including the president-elect as well as the immediate past-president in participation in Association activities as well as in regional and sectional hospital meetings is very sound.

In the course of my education during the past year as president-elect, I have been wondering about the proper role of the president of the Association in relation to the staff, the membership and the public. Presiding at meetings, acting as spokesman for the membership of the Association, and representing hospitals to the public, to political and to professional organizations would appear to be responsibilities of the president that are clearly defined. Having had experience with the councils and the coordinating committee, I am hopeful that I can assume these responsibilities successfully, if I can avoid being pontifical, or embarking upon foreign seas without adequate charting. Far more nebulous is the mechanism by which the president, the board of trustees and the administrative staff work together to develop policy and long-range planning for the Association and its member hospitals. The position of the president of the American Hospital Association is similar to that of the president of the board of trustees of a typical hospital. The Director, Doctor Crosby, is the chief executive officer or administrator—the expert and consultant; the president is the individual who works with the administrator to see that the board of trustees and the membership develop policies, but who does not interfere in the administration of the organization! The president of the American Hospital Association has the additional responsibility as does the president of a hospital board of representing the membership so that their policies and plans may be developed judicially and intelligently, and with due regard to the opinions and needs of all the hospitals and patients throughout the country.

I hope that I will be able to conform to this pattern and would welcome your comments and suggestions.

Albert W. Snoke, M.D.

Albert W. Snoke, M.D., president
American Hospital Association

engineering and maintenance

in setting up a maintenance schedule,

don't bypass the kitchen

by GEORGE E. ZOBAC

HOW MAINTENANCE and repair work is carried out is a major factor in the operating efficiency of the hospital; any savings in time and labor will be fully reflected in the over-all operating expense of the institution.

Most maintenance and repair work in the kitchen can be done with the least interruption at night. Using a written schedule, the night duty maintenance man can make necessary repairs and adjustments and complete his periodic inspection without inconveniencing kitchen workers or disrupting the operation of that department. It is sometimes necessary to make temporary repairs during the day but the major work can be done when the department is not in full operation. The less disruption in any department when it is in operation, the bigger the contribution of the maintenance department to the comfort and safety of the hospital's patients.

Kitchen equipment is operated mostly by workers who are not mechanically trained. For this reason, it is imperative that some period of training be given to the person whose duties include operating mechanical equipment. This training period, which at the outset might seem superfluous, forms the groundwork for all preventive maintenance. If a piece of equipment is operated by persons schooled in its limitations, one causative factor in mechanical failure is at least partially eliminated.

In setting up a preventive maintenance program, the chief engineer should first gather full information on every piece of kitchen equipment. This information should be logically catalogued for ready accessibility. For example, a set of cards can be kept—one card for each piece of equipment. Pertinent information about the equipment, such as location, serial number, type of bearings, rating, and lubrication requirements can be listed on the cards.

Notation should also be made as to mode of operation (steam, gas, electric, or hydraulic), date of installation, and if available, the cost of the equipment. Most of the facts needed on the cards can be obtained from the name plate of the equipment. Additional information can be found in service manuals or literature concerning the equipment available from the manufacturer. An equipment survey by the service department of an oil supply company will furnish necessary facts about lubrication requirements.

ESTABLISH SERVICING PLAN

After a card file or similar system has been set up, the actual plan for routine servicing should be established. This plan includes determination of (1) frequency of inspection, (2) persons responsible for routine inspection, (3) major points to be checked, (4) relative importance of the equipment to the operation of the department, and (5) the person to whom the inspector makes his report.

Once this plan is worked out, a schedule should be posted informing employees of their respective duties. This schedule should also include information on proper lubrication, maximum immediate repairs, and existence of worn and/or defective parts requiring replacement. The chief engineer, in addition to integrating the program, should maintain an adequate stock of critical replacement parts.

EVALUATING REPAIR WORK

A constant evaluation record of repairs and performance should be kept. From this record can be extracted information on the cost of repairs (is it too high because of old or worn-out equipment?) and the frequency of repairs (is service interrupted too often to permit efficient departmental operation?). The record can be used as a basis for recommendations regarding replacement of various pieces of equipment. It will serve as concrete evidence, for presentation to the administration, of the seriousness of equipment failure.

A plan for periodic complete overhauls should be established. At the same time it can be determined which units are most critically in need of overhaul and if the work can be done by hospital personnel or if it should be sublet. Smaller institutions sometimes find it more economical to have an outside contractor or service organization perform major overhauling, as these hospitals may lack either the necessary trained manpower or proper equipment.

The kitchen equipment maintenance system outlined here cannot be made to function at top efficiency overnight. With close cooperation between the kitchen and engineering departments, however, it will function smoothly after a period of patient trial and error. If carried out properly, the plan will help make the tasks of the engineer easier and pleasanter. Eventually, it should lead to higher employee morale and better patient care. ■

George E. Zobac is chief engineer of Bethany Methodist Hospital, Chicago.

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tissue committee records and the law

HOSPITALS DESIRING accreditation by the Joint Commission on Accreditation of Hospitals are required to meet certain criteria, one of which is the appointment and maintenance of a tissue committee,[1] which has the following functions:

The Tissue Committee shall study and report to the staff, or the Executive Committee of the Staff, the agreement or disagreement between preoperative diagnosis and reports by the pathologists on the tissues removed at operation. The Committee shall meet at least once a month and submit to the Executive Committee a report in writing to be made a part of the permanent record.

As has been pointed out by both Dr. MacEachern[2] and Dr. Ponton,[3] the medical staff of a hospital has an obligation to the patients entering that hospital to see to it that everything possible is done to ensure that the professional services rendered will be at least equal to average standards. To fulfill this obligation, considerable reliance must be placed upon the professional accounting methods used in the hospital. Certainly one of the most valuable of these methods is the tissue committee. (Some hospitals refer to the committee functioning in this capacity as the audit committee, surgical review committee, tumor and tissue committee, or the like.)

In recent months, a number of hospital administrators and committee members have expressed concern as to the possible use and abuse of tissue committee reports by attorneys seeking material on which to base a malpractice action or seeking potential expert witnesses to support a suit already filed or contemplated. Questions such as the following have been asked: Are tissue committee reports available to attorneys in any way? May they be subpoenaed? May they be examined in pretrial discovery proceedings? Are they admissible in evidence? May they be used on the cross-examination of a committee member who is testifying as an expert? Are they, in fact, of any probative value on the issue of the negligence of a surgeon whose cases may have been considered by the committee? These are pertinent questions. They are also difficult questions to answer because the law gives due consideration not only to the protection of physicians from unjust claims but also to the protection of patients having just and meritorious claims. Before attempting to answer these questions, however, it will be helpful to review the usual make-up, activity, and goals of a tissue committee.

A tissue committee is a committee of the medical staff of a hospital, or a subcommittee of the executive committee of the medical staff, and is usually appointed by the president of the medical staff pursuant to the bylaws of the hospital.[4] At the time of its organization, the committee decides what types of cases are to be reviewed, how the review is to be performed, and what limitations, if any, are to be placed upon the committee.

In one instance, for example,[5] a committee decided to review all operative cases in the following six categories: (1) operations involving reproductive organs; (2) appendectomies; (3) cases in which the pathologist reported no, or minimum, pathological changes; (4) cases in which there was marked disparity between preoperative and postoperative diagnosis; (5) emergency surgery, including not only the operations

This article appeared in the *Journal of the American Medical Association*, Medicine and the Law, April 7, 1966, p. 1238.

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performed at night and over weekends but also all surgical cases admitted other than during the regular hours, 2 p.m. to 5 p.m.; (6) cases in which tissue was not removed, as in lysis of adhesions, uterine suspensions, and cases in which the incision was closed without consummation of definite surgery. Cases falling within these categories are sent to the committee chairman, who assigns the various charts to the committee members. Members do not review their own charts or those of their associate's patients. The committee meets monthly, or as often as may be necessary. Cases are presented by number only so that the identity of an individual patient and surgeon is not disclosed. The conclusion of the committee in each case is made a part of the permanent files of the medical staff. These conclusions may, of course, take various forms, but in most instances they will be tabular rather than narrative and will state only the finding and not the facts upon which the finding is based.

In some institutions a report form[6] is used, showing a further analysis in each case and indicating whether surgery was justified and whether the preoperative and the tissue diagnosis agreed. Each report indicates the case number, the surgeon's number, and the final diagnosis on operation. Such a form, tabulated for any particular period of time, will disclose (1) the number of times a specific type of operation is performed by all surgeons, (2) the number of times a specific type of operation is performed by an individual surgeon, (3) the total number of operations performed by all surgeons, and (4) the total number of operations performed by an individual surgeon. The form also reveals the number of justified surgical procedures, the number of operations in which tissue was removed justifiably, the number of operations in which normal tissue was removed, and the number of operations in which a correct preoperative diagnosis was made.

In attempting to evaluate surgical procedures, the average tissue committee studies each patient's clinical record, history, physical examination, laboratory data, diagnostic tests, operative findings, follow-up notes, and discharge notes. In this way the tissue committee is able to evaluate the justification for surgery performed by the members of the medical staff of the hospital as well as the quality of surgical care furnished to patients. The discovery of negligence is neither the goal nor an indirect result of a tissue committee study. It should be understood that the word "justification" is used in a medical sense and not in a legal sense.

Furthermore, tissue committee reports, as such, contain no factual information, such as is found in the patient's hospital record. As Dr. Ponton[7] points out:

The purpose of all staff meetings is lost sight of when there is an attempt to throw blame on any individual. The medical staff is looking for sources of error which may have occurred and only incidentally will it discover who made the error. When emphasis is placed on a person who made the error rather than on the error itself, ill feeling results and consequently there can be no effective effort at correction.

What then is the legal status of this committee report or of the index of the activities of an individual physician that it provides? Immediately, two entirely different questions are presented. Are the records of a tissue committee subject to subpoena or pretrial inspection, and are they admissible in evidence in a lawsuit? For the purpose of this discussion, it will be conceded that, upon compliance with the pertinent statutes and court rules of the state in question, such records may usually be subpoenaed. To what use they may be put once they appear in the courtroom will depend upon the type of case being tried. If it is a suit against a hospital for failing to use due care in the appointment or retention of a staff physician, the tissue committee report on that surgeon would seem to be very pertinent. Its pertinence in a malpractice action against a staff member is less clear. To be used in the malpractice case it would probably be argued that the report is a part of a patient's clinical record. Certainly, this report does not fall within the generally accepted definition of a patient's clinical record, which is divided into three parts: (1) nurses' records, (2) records and reports from adjunct and special departments, and (3) the medical record proper, that is, that part that is the direct responsibility of the physician.[8] The tissue committee report has no bearing upon what is wrong with a patient or what is, or should be, done; it is, instead, a "postpatient" activity record, taking place after the patient has left the hospital.

Even though the records of a tissue committee do not constitute a part of a patient's hospital or clinical record, they are not, for that reason alone, inadmissible in evidence. We must therefore look to the general rules of evidence. Evidence is said to be hearsay when its probative force depends on the competency and credibility of some person other than the witness.[9] Stated another way, any statement offered in evidence that is not made by the author as a witness before the court, or when he is subject to cross-examination, is hearsay. Basically, therefore, hospital records are hearsay evidence, and the courts of some states exclude them simply on that ground.[10] There are, however, a number of common law and statutory exceptions to the hearsay rule that permit the use of hospital records as evidence.

The common law exceptions are as follows:

1. Shopbook rule. A common law exception to the hearsay rule permits the introduction in evidence of business records or books of account, made as original entries, and relating to sales or service. It is doubtful that the records of a tissue committee fall within such a classification.

2. Entries made in the regular course of business. Entries, if made by a person whose duty it is to make them, who routinely makes such entries, and who has no motive to falsify, are admissible upon proper authentication. This presents a question as to whether tissue committee reports are in any sense entries made in the regular course of business of a hospital.[11]

The business of a hospital, it is self-evident, is to diagnose and treat its patients' ailments. Consequently, the only memoranda that may be regarded as [business rec-

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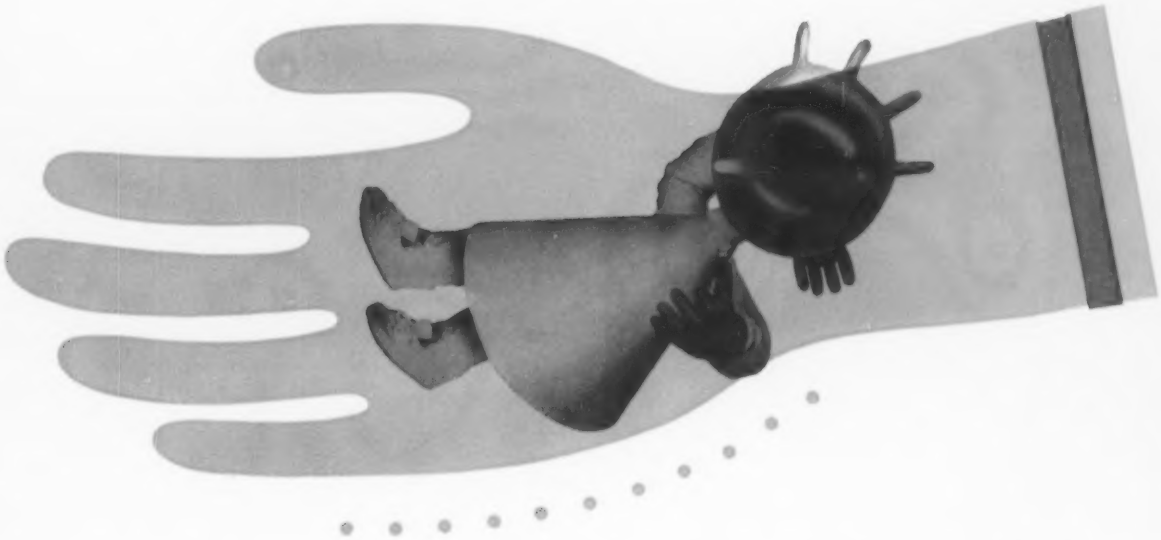

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ords] . . . are those reflecting acts, occurrences or events that relate to diagnosis, prognosis or treatment or are otherwise "helpful to an understanding of the medical or surgical aspects of . . . [the particular patient's] hospitalization."

It should be noted in any court that the regular entry exception at common law only applied if the clerk who made the record was deceased or unavailable.

3. Official records. Records of public hospitals, if required to be kept by law, are admissible as public records. This exception, however, would not apply to the records of private hospitals, which are not kept by virtue of statutory direction.

4. Admissions against interest. These are statements made by one person to another that are in conflict with the interests of the person making the declaration. The tissue committee records cannot logically be considered as declarations against interest.

The statutory exceptions are as follows:

1. Shopbook rule. This common law rule has been enacted into statutory law in a number of states.[12] It permits the use in court of records kept in the regular course of a business at the time of the act referred to or within a reasonable time thereafter, if it is shown to be the regular course of such business to make such entries. Business is defined to include "profession, occupation and calling of every kind."

2. Uniform Business Records as Evidence Act. This act, which is quite similar to the statutory shopbook rule, has also been adopted in quite a number of states.[12] It applies to any type of business and refers to records made in the regular course of such business at or near the time of the act referred to.

Either of the foregoing types of statutes would probably be interpreted as sufficient authority for the admissibility of tissue committee reports in evidence if it be conceded that they are made in the regular course of business. It would still be necessary, however, to establish that the matter sought to be introduced was relevant to the issue involved.[13] For example, it would seem to be irrelevant to attempt to establish the malpractice of Dr. X in treating Y by introducing a tissue committee report showing, for example, that in a certain percentage of appendectomies performed by Dr. X there was a discrepancy between the preoperative diagnosis and the postoperative pathological findings. The inference of negligence, if any, is too remote to be valuable.

To help the public identify some of the devices, gadgets, and machines used for so-called "treatments" or "cures" of many diseases, the AMA's Bureau of Investigation has issued a pamphlet on mechanical quackery. A check list for identification of quacks in the local community is included.

The pamphlet will be distributed primarily at AMA exhibits on quackery at medical society meetings, health fairs, museums, etc. It will also be sent by mail to those who request copies from the Bureau.

Further, if the tissue committee report constitutes a conclusion upon the ultimate question to be determined by the jury, it would be inadmissible in most states.[14]

A final point dealing with the general question of the admissibility of any record relating to medical and surgical care is the privileged communications law of any particular state. These statutes and the court decisions construing them vary considerably. In general, however, they apply only to information that a physician needs in order to diagnose or treat his patient effectively. Since the reports of a tissue committee do not in any way influence diagnosis or treatment, such laws should not affect one way or the other the admissibility in evidence of such reports.

It will be apparent from the foregoing discussion that it is difficult to arrive at any uniform rule relating to the admissibility in evidence of tissue committee reports. Court decisions on the subject are conspicuous by their absence. About the most that can be said is that, if there is no statute in a state specifically requiring a hospital to have a tissue committee and to maintain and preserve a record of its activities, the records of a voluntary committee are probably not admissible in evidence in a malpractice action against a staff member for one or more of the following reasons: 1. They are hearsay. 2. They are irrelevant. 3. They are of no probative value. 4. They would constitute a conclusion upon the ultimate issue and would thus invade the province of the jury.

Apart from purely legal considerations, there are other reasons why such records should not be admissible. 1. Even though they may not be protected by the strict wording of a privileged communication statute, they are certainly of a highly confidential nature. 2. Hospitals would be discouraged from conducting intraorganization studies for the purpose of improving the competence of its employees and staff members.

As long as tissue committees continue to operate as training aids, deal only in case numbers, maintain tabular rather than narrative conclusions, and make only general medical findings rather than specific findings of individual negligence, it is doubtful that the reports of their activities will be admissible in evidence against a staff member charged with malpractice. ■

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SOCIETY AND HEALTH. Walter E. Boek and Jean K. Boek. G. P. Putnam's Sons, New York. 1956. 301 pp. $4.50.

This book attempts to give its readers a basic orientation in the social sciences, drawing upon materials from biology, medicine, psychology, anthropology and sociology to do so. Its virtues and faults lie in this heady brew. The book sketches in broad outline form a picture of the human individual as he is born into the world, is reared within the family, goes forth to be educated by his playmates, teachers and religious leaders, and finally achieves adulthood and takes on occupational status. It shows how adult attitudes and behavior are influenced by this upbringing.

The authors selected the hospital and its occupational groups for their examples of adult society. They describe a mythical institution, Meredith Hospital, and talk about its organizational structure, the wide variety of people who work within it, and those who come to it as patients. One of the most interesting chapters deals with social stress and illness. It discusses among other things various stereotypes concerning hospitals, doctors and nurses which patients bring with them to the hospital, and how these stereotypes influence chances for recovery.

The book affords a tantalizing glimpse into a wide variety of subjets, giving a perspective of how vitally important all of them are in gaining an understanding of why people behave as they do within hospital situations.

This work should be useful to students of the health professions, particularly those whose formal education has not yet included advanced courses in the social sciences. Beginners of all ages and levels of experience should enjoy reading it, whether formally enrolled as students or already working as professionals.

The book is an excellent companion piece to the publisher's *The Give and Take in Hospitals*, also published in 1956, which describes actual situations found in six representative hospitals and tells how persons encountering the situations reacted to them.—EDITH M. LENTZ, *assistant professor and research director, course in hospital administration, University of Minnesota.*

Two-year nursing program

PRINCIPLES OF ADMINISTRATION IN JUNIOR AND COMMUNITY COLLEGE EDUCATION FOR NURSING. J. F. Marvin Buechel. New York, G. P. Putnam's Sons, 1956. 255 pp. $3.50.

NURSING EDUCATION IN JUNIOR AND COMMUNITY COLLEGES, sponsored by American Association of Junior Colleges; Cooperative Research Project, Columbia University; National League for Nursing, New York, 1956. 76 pp. $1.

The two-year nursing program is an important experiment in today's search for a greater supply of bedside nurses.

Because Mr. Buechel's book is almost exclusively concerned with the role of the college in nursing education, it affords administrators an insight into an educator's concept of the problem. Without denying the contribution of modern educational concepts, one nevertheless wishes there had been greater emphasis on the hospital's vital role in determining the education of persons who will care for the sick. This reviewer further questions an assumption that service rendered by the three-year graduate is of little benefit to either herself or the hospital. If the book is correct in asserting that schools of nursing must qualify a nurse to *begin* practice on graduation, rather than retain her as a student in the school until she has developed a high degree of skill through repetitive practice, then administrators who have been quoted as saying the two-year graduate is at least equal and perhaps even better than the three-year graduate are on shaky ground.

Nursing Education in Junior and Community Colleges is a report of a conference held earlier this year by the three sponsoring groups presenting opinions of conference speakers on the various aspects of junior college education for nurses. While some of the speakers approve the program unconditionally, others stress individual differences among doctors, hospitals and even nurses themselves as factors contributing to the performance of a nursing school graduate. Perhaps the wisest critique of this type of nursing education was voiced by a member of the Cooperative Research Project, who said, "It is important that our program offer no conclusions at this point."—*Jacques Cousin, director, Oakwood Hospital, Dearborn, Mich.*

Personal injury litigation

THE DOCTOR IN PERSONAL INJURY CASES. Harold A Liebenson. Chicago, Year Book Publishers, Inc., 1956. 123 pp. $4.

This book is designed to orient the medical practitioner on basic court procedure in personal injury cases. It briefs the doctor on what to expect when he is called upon to testify. Subject matter includes a discussion of direct and cross examination; opinion evidence; value of complete medical records and reports; use of lay language in the proper presentation and analysis of medical problems; and the need for complete sincerity and cooperation in dealing with the jury and opposing counsel.

In view of the apparent increase in the number of medical malpractice cases and other types of personal injury litigation, every doctor should be familiar with the basic essentials of court procedure. Written in concise layman's language, this book could be a valuable addition to a hospital medical staff library.—MARION J. FOSTER.

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hospital dietetics abroad

Last July dietitians from eighteen countries met in Rome for the Second International Congress of Dietetics to exchange views on methods of applying the findings of basic nutrition to the people's welfare and on problems of training and organization arising from the growth of the dietetic profession. The editors of HOSPITALS have invited members of three European dietetic associations to share with us their triumphs and their challenges in the field of hospital dietetics.

IN THE NETHERLANDS 84 of the approximately 160 dietitians actively engaged in their profession work in hospitals. The number of dietitians working in a single hospital may be one to seven, which depends, among other things, upon the size of the hospital.

In some hospitals the dietitian supervises the whole kitchen department, including the planning and preparation of diets. However, the dietitian also may be in charge of the management of the modified diet kitchen and the department kitchen, regular contact with modified diet patients and the various departments of the hospital, and instruction of patients in the clinic and outpatient department.

If a hospital dispenses with the services of a dietitian, management of the kitchen rests with the head of the kitchen or with the first assistant under the supervision of the head of the domestic department. This factor depends entirely upon the size of the hospital and the training of the staff members in question.

The types of person sought for these positions are the home economists in institutions and the foods and nutrition teachers, who have been trained at home economics schools and have served a subsequent term of practical training in several institutions. These positions are also held by persons who have only had practical experience. Hospitals aim to appoint the above mentioned qualified personnel in preference to the others. In The Netherlands there is not only a shortage of dietitians but also of other qualified personnel for domestic work.

In the smaller hospitals without a dietitian the week's menus are compiled by the head of the kitchen department (in effect a dietitian), sometimes in cooperation with the administrator. In large hospitals menus are prepared by a menu planning committee. Members of the committee may include the matron, dietitian, head nurses, administrator, head of the kitchen, head of the modified diet kitchen, head of the domestic department, matron of the sister home, chief cook and butcher. In the majority of cases the menu has to be approved by the matron and administrator.

As a rule catering is done by the head of the kitchen and/or the head of the central stores, in cooperation with the administrator. Sometimes the head of the kitchen asks the administrator to do the catering.

Distribution to the patient

The distribution and transport of food in some large hospitals, in which the various departments are established in separate buildings, are carried out mechanically by means of a tractor to which some small, heated or unheated, food carts are attached. In some hospitals where the transport of food does not take place across an open field, the carts are brought to the various departments by the nurses and/or domestic personnel.

Food for patients on a normal diet is prepared in the central kitchen, transported in containers to the department kitchen and served there by the head nurse or her assistant. Food for the class (private) patients is served by the kitchen staff or in the department kitchen by the nursing staff and then delivered to the patient. Some hospitals use specially constructed food transport carts from which the food can be immediately served in the passage before the wards or in the wards themselves.

Modified diets are prepared in the central kitchen or in a separate diet kitchen. If a dietitian works in one of these units, as a rule she ladles out and divides the food into individual servings, weighs it if necessary and delivers the trays to the various departments.

If a hospital does not employ a dietitian for its kitchen department, but only one for the other departments, the food is generally sent to these departments in a "raw" or "unfinished" state and finished off by the dietitian for the patients' immediate use.

Modified diets

If the hospital does not employ a dietitian, the modified diets are prepared in the main kitchen or partly in the main kitchen and partly in the departments by the nurses. Approximately 25 to 50 per cent of our total hospital patients are on modified diets.

In Dutch hospitals "standard" diets are used for certain modified diet patients; for example, sodium restrictive diets, certain stomach diets and sometimes measured or weighed (diabetic) diets. The num-

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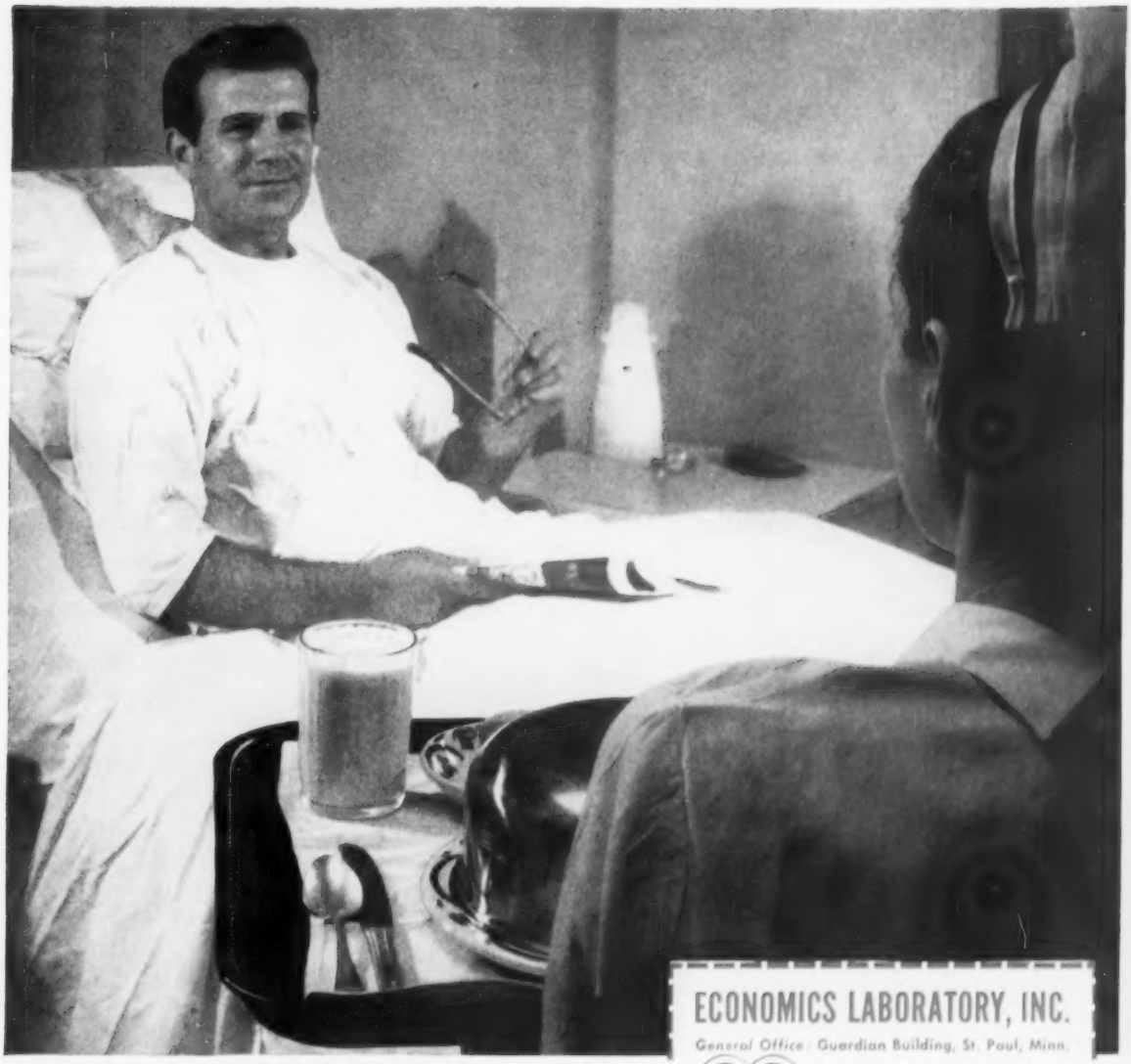

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ber of "standard" diets amounts to approximately 50 per cent of the total number of modified diets. In the hospital an effort is made to adapt the food for modified diets as much as possible to the food used for patients on a normal diet.

For other modified diet patients the dietitian as a rule will compile individual diets according to the physician's prescription. At the same time the patient's food likes and dislikes will be taken into consideration. The extent of this service depends largely upon the amount of time the dietitian has available for maintaining personal contact with the patients. In The Netherlands approximately one third of the modified diet patients are on a sodium restrictive diet. This diet is generally prescribed for heart and kidney diseases and/or weight reduction.

Meeting the shortage

In order to meet the demand for dietitians in The Netherlands the length of the dietetic training course was altered some time ago. Formerly only a foods and nutrition teacher (term of training, four and one-half years) could become a dietitian. Today a special preliminary training program lasts three years.

We also endeavor to improve the standard of the home economics courses so that home economists will be able to assist the dietitian. The Netherlands Dietetic Association and directors of the training courses for dietitians have declared themselves decidedly against calling the graduates "dietetic assistants" as this would create the impression that they are on the same level as the dietitian.

The Netherlands Dietetic Association encourages the appointment of dietitians in some small hospitals and in small towns to work in the local hospital, home for the aged and children's home at the same time. The boards of a number of homes for the mentally ill in one of the provinces have already appointed a central dietitian and the same course has been adopted by the boards of some homes for the aged in Amsterdam. In the near future this procedure will probably be followed by more institutions.

In the same way various small hospitals which dispense with the services of a dietitian have invited the assistance of dietitians who serve in other hospitals.

Furthermore dietitians who work in the department for group feeding of the Education Bureau for Food and Nutrition also give assistance in diet composition and preparation to institutions, such as hospitals, homes for the mentally ill, children's homes, tuberculosis hospitals and homes for the aged. The dietitian acts as a consultant in an institution for a period of three to six days for a fee of $14.—TH. F. S. M. VAN SCHAIK, *president of The Netherlands Dietetic Association, The Hague; and* A. W. S. VAN BERGE, *dietitian of the institutional management department of the Education Bureau for Food and Nutrition, The Hague. Data for this report were supplied by the following dietitians in The Netherlands: Sister M. Soteria and the Misses C. Duyvendak, H. Kenter, L. Kooreman, M. Schuurs and T. Veerdig.* ■

IN ITALY hospital dietetics is in the pioneering stage of its development. There are a few qualified dietitians working in a few hospitals throughout the country. For the past eight years a modern central service of food and dietetics has been functioning at the Hospital di S. Spirito in Rome. Eighteen dietitians were employed by this service in 1952. This service represents a consultative body for all the problems concerning the supply, preservation, processing and distribution of food in the hospitals of Italy.

The latest available statistics indicate that there are approximately 225 nurses, 55 physicians and 20 cooks who have specialized in dietetics. A number of these dietitians are employed by various social and health communities.

The didactic activities for the specialization of dietitians only date back 15 years, with the establishment of the Institute of Food and Dietetics in Rome in 1941. Five years later the activity was extended to the New Hospital of Niguarda in Milan.

Distribution to the patient

In Italy the general trend of food distribution to the patient is from a central kitchen. Since there is a definite lack of professionally qualified personnel, most of the food preparation and service activities in hospitals are directed by nonprofessional personnel.

Modified diets

A large percentage of the patients are on modified diets. To simplify modified diet ordering and preparation, the Institute of Food Service and Dietetics in Rome in April 1954 published a diet manual, which is now in use in Rome hospitals. Pertinent data on 17 modified diets is presented in chart form.

Meeting the shortage

There is a great need for more professionally qualified personnel to direct and supervise the dietary services of Italy's hospitals. The efforts of the Italian Dietetic Association and of the professionally qualified personnel are now being directed toward increasing the number and quality of the personnel available. In the meantime our professionally qualified dietitians are waiting for acceptance and for proper recognition of their contribution to the improvement of dietetics.—PROF. EMIDIO SERIANNI, M.D., *secretary general of the Italian Dietetic Association, Rome.* ■

IN SWEDEN the first training course for dietitians dates back to 1917. Today approximately 40 dietitians are graduated every year.

At first the employment of these professionally qualified personnel was solely confined to hospitals. Gradually, however, their field of operations widened to military mess halls, welfare wards, school kitchens, factory and office canteens, and as nutritionists in different institutions.

This expansion has many advantages, however, not from the med-

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ical viewpoint. Hospitals are finding it increasingly difficult to secure dietitians for their kitchens, which are large and entail a heavy burden of work. Dietitians are naturally attracted by the more regular shorter, working hours (including free Sundays and holidays); longer vacations and other benefits. Newly-graduated dietitians are also dissuaded from entering hospital dietary service because they usually have to start in an assistant's post; while in other fields they are given full responsibility immediately.

At the present time there are not enough dietitians in Sweden. The shortage is more pronounced as new fields open up to dietitians. Basically this shortage is a consequence of Sweden's low birth rate around 1930. Its recent effect on the dietetics profession has been to decrease the number of women —in an occupational world with too few women—who sign up for training courses.

All full-fledged hospitals in Sweden have graduate dietitians in charge of their kitchens. Only in the very smallest hospitals, such as infirmaries with 50 or 60 beds, the matrons are in charge and are assisted in the kitchen by a well-trained cook.

In larger hospitals the dietitian is assisted by one or more assistant dietitians. A hospital must have 250 or 300 beds to warrant the employment of an assistant; in hospitals of fewer beds, the head dietitian does the work herself. In institutions like Caroline Hospital with 1,650 beds, the head dietitian has six assistants.

Distribution to the patient

A Swedish hospital dietitian is responsible for the food until it is placed in tray carts for distribution to the wards. Carts are moved by male personnel from the kitchen to the ward, where the nurse assumes responsibility. In some cases the food is transported from branch kitchens by lift instead of by cart.

Each day's supply of food for the ward is ordered by the nurse on a requisition form, which must reach the dietitian's office early in the morning of the previous day. The different requisitions are then compiled at the office and serve as guide for the dietitian in purchasing and food production planning. The work of preparing menus and modified diets is done by the dietitian and her assistants.

Similarly the dietitian is responsible for budgeting dietary funds for the year. Extra funds are approved only if there is a general rise in food prices. Added costs incurred by a higher proportion of modified diets or by certain changes in diet composition must be budgeted for in the normal appropriation and cannot be used to justify a request for extra funds.

Modified diets

Considering the present trend in dietetics, modified diets pose quite a problem for us in Sweden. Formerly approximately 20 per cent of all hospital patients were on modified diets, but this proportion now stands at more than 35 per cent. Although most patients are kept on a general soft diet, there is now a contrary trend towards greater differentiation in diets. Being more individual in nature, these diets naturally take a great deal more time and labor to prepare. Where once kidney and

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weight reduction diets predominated, the leading types of modified diets today are sodium restrictive, high protein and low fat.

It should be mentioned that the general soft diet is not as austere as before. It is undergoing a simplification, which in many cases had led to its preparation being transferred from the modified diet kitchen to the general diet kitchen.

Meeting the shortage

Since a dietitian commands a relatively high salary, some of the smaller institutions feel that they cannot afford to employ one. In such situations either of these two solutions has been tried: The hospital may secure its food from a larger hospital kitchen in the vicinity or from a hospital to which it is related administratively. The second solution is to have an outside dietitian serve as a consultant. In this connection, the progress of current experiments with school meals is attracting great attention. Thus a large institutional kitchen is assigned to prepare from 10 to 20 meals, according to the number of pupils attending a small school. These meals are quick-frozen and sent to the school once a week for storage in a freezer. The daily meal prescribed by the menu is then heated and served to the children. In this way, the small school lags one to two weeks behind in the menu.

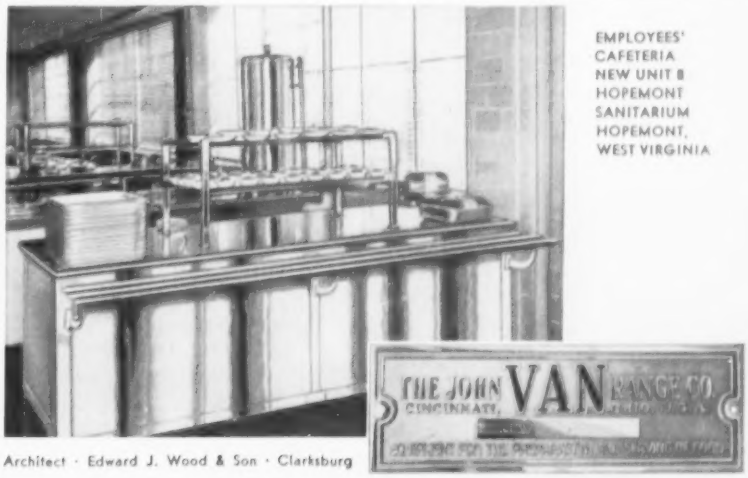
Promoting dietetics

As compared with other professions open to a career-minded young woman, dietetics is heavier work, more demanding and involves more responsibility than the average position. Every effort, therefore, should be made to enhance the attractiveness of dietetics in other respects in order to secure adequate enrollment in training courses.

The basic approach in selling dietetics as a profession is to point up the vital and absorbing aspects of the work. For one thing you will seldom find a Swedish dietitian who regrets her choice of profession. Although dietitians are finding it harder and harder to obtain competent help in sufficient numbers for hospital kitchens, all of them agree that their jobs are interesting and rewarding.

One factor that should persuade dietitians to choose a hospital career are the kitchens in Swedish hospitals. They are usually modern and well-equipped. In this field Sweden compares very favorably with other countries. The kitchens are also amply provided with storage space, even refrigerated lockers. In recent years we in Sweden have increasingly come to appreciate what quick-frozen foods can do to reduce labor and more and more institutional kitchens are installing frozen food equipment.

In bargaining collectively for our interests, the Swedish Association of Dietitians has not been content to ask for higher salaries. The Association has also sought and succeeded in advancing the state salary levels at which we are placed. Thus positions are open to assistant dietitians at salary levels 15, 16 and, at the larger hospital, 18. Dietitians are placed at salary levels 19 (representing hospitals with less than 20 beds), 21 or 22 (the large hospitals). Finally they can attain levels 23 to 25 as nutritionists. According to law, all of these official positions must be de-



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clared vacant, which means they are open to one and all. In this way we feel that we have ensured a career for qualified young people that holds good opportunities for advancement within a reasonable time after their graduation.

The Association also sponsors a week-long series of advanced courses as part of its biennial conference. These conferences enable members to catch up with developments in all areas of their profession. We also publish relevant news in our monthly periodical.—MARGARETTA NEUMULLER, *president of the Swedish Association of Dietitians, Stockholm.* ■

Master Menus for November 1-15

THE MASTER MENU is planned to provide good food for every hospital patient. Time and effort have been expended to provide menus that are nutritionally adequate, that have therapeutic and psychological value for the patient and promote good public relations for the hospital. Consideration has been given to the variety of menu items, preparation method, flavor, color and texture.

The general diet forms the basis for the seven most frequently used modified hospital diets included in the menu. Items 1, 3, 4 and 6 on the breakfast menu, 7, 8, 9, 11, 13, 15, 16 and 17 on the dinner selections and 22, 23, 24, 28, 29, 30, 31 and 36 luncheon or supper menu are for the general or normal diet. This general diet has been planned to reduce to a minimum the modification necessary to meet all the patients' therapeutic food needs.

The Master Menu also provides a complete menu for the following modified hospital diets: soft, full liquid, high protein, high calorie, low calorie, low fat and measured or weighed. For example, on the breakfast menu the soft diets would receive items 2, 3, and 4; the full liquids, item 2; high protein, 1, 3 and 4; high calorie, 1, 3, 4 and 5; low calorie, 1, 3 and 4; low fat, 2, 3 and 4; and measured or weighed, 1, 3, 4 and 5.

Master Menu kits containing the revised wall cards, several transfer slips and the *Master Menu Diet Manual* are available to users of the menus. The kits are priced at $2 and may be secured by writing the editorial department of **HOSPITALS**, JOURNAL OF THE AMERICAN HOSPITAL ASSOCIATION. Single copies of the manual are $1.50.

November 1

1. **Orange slices**
2. Orange juice
3. **Crisp rice cereal or oatmeal**
4. **Scrambled egg**
5. Link sausage
6. **Toast**

7. **Apricot nector**
8. ———
9. **Rolled shoulder of lamb or baked**
10. Beef sweetbreads with brown mushroom sauce
11. **Paprika potatoes**
12. Paprika potatoes
13. **Broccoli club style**
14. Mashed yellow squash
15. **Cinnamon apple salad on endive**
16. ———
17. **Peach fluff pudding**
18. Peach fluff pudding
19. Orange gelatin
20. Unsweetened canned peaches
21. Consomme

22. **Washington chowder**
23. **Crisp crackers**
24. **Creamed dried beef on Chinese noodles**
25. Toasted minced chicken sandwich—cranberry jelly
26. Cold sliced veal
27. Baked potato
28. **French cut green beans**
29. **Fresh pear, orange and seedless grape salad**
30. **Cream mayonnaise**
31. **Lady Baltimore cake**
32. Lime gelatin cubes
33. Lime gelatin cubes with custard sauce
34. Unsweetened canned prune plums
35. Tomato juice
36. ———

November 2

1. **Tangerine**
2. Grapefruit juice
3. **Rolled wheat or corn flakes**
4. **Poached egg**
5. Bacon
6. **Toast**

7. **Essence of celery soup**
8. **Whole wheat crackers**
9. **Baked salmon loaf—cucumber sauce or barbecued spareribs**
10. Baked salmon steak
11. **Parsley whole potatoes**
12. Parsley whole potatoes
13. **Harvard beets**
14. Diced carrots
15. **Stuffed prune salad with pecan garnish**
16. **Cream mayonnaise**
17. **Peppermint ice cream-chocolate sauce**
18. Vanilla ice cream
19. Pineapple whip
20. Unsweetened canned bing cherries
21. Orange juice

22. **Oyster stew**
23. **Oyster crackers**
24. **Openfaced toasted cheese and bacon sandwich**
25. Baked cheese sandwich—asparagus
26. Cottage cheese—asparagus
27. Baked potato
28. ———
29. **Tomato and parsley salad**
30. **French dressing**
31. **Canned peaches—Hawaiian jumbles**
32. Canned peaches
33. Vanilla pudding with apricot nector sauce
34. Fresh apple
35. Apple juice
36. ———

November 3

1. **Tomato juice**
2. Prune juice with lemon
3. **Puffed rice or brown granular wheat cereal**
4. **Soft cooked egg**
5. Canadian bacon
6. **Corn muffins**

7. **Vegetable soup**
8. **Saltines**
9. **Liver and bacon or Russian salad bowl—Russian dressing**
10. Broiled lamb chop
11. ———
12. Whipped potatoes
13. **Corn and Lima bean succotash**
14. Green peas
15. **Relish plate—spiced crabapple, celery and ripe olives**
16. ———
17. **Cottage pudding with banana custard**
18. Sliced banana in orange juice
19. Orange ice
20. Unsweetened canned peaches
21. Grapefruit juice

22. **Cream of tomato soup**
23. **Crisp crackers**
24. **Old-fashioned beef and vegetable stew**
25. Minced veal on toast
26. Hot diced veal
27. Paprika potato balls
28. **Chopped spinach**
29. **Pear blush salad on chicory**
30. **Cream mayonnaise**
31. **Grape juice gelatin, whipped cream**
32. Grape juice gelatin
33. Grape juice gelatin
34. Pink grapefruit sections
35. Mixed fruit juice
36. **Toasted French bread**

November 4

1. **Fresh grapes**
2. Blended citrus juice
3. **Scotch bran brose or puffed wheat**
4. **Scrambled egg**
5. Grilled ham
6. **Cinnamon toast**

7. **Tinted citrus juice**
8. ———
9. **Roast chicken with giblet gravy or broiled lamb chops**
10. Roast chicken
11. **Parsley potatoes**
12. Parsley potatoes
13. **Cauliflower with cream sauce**
14. Diced beets
15. **Sliced lettuce salad**
16. **Chiffonade dressing**
17. **Chocolate ice cream**
18. Chocolate ice cream
19. Fruit ice
20. Fresh pineapple
21. Consomme

22. **Split pea soup**
23. **Croutons**
24. **Ham and eggs on toast—au gratin**
25. Omelet
26. Omelet
27. Stuffed baked potato
28. **Green beans**
29. **Sliced orange and avocado salad**
30. **Mayonnaise**
31. **Burnt sugar cake**
32. Canned pears
33. Floating island
34. Fresh pear
35. Pineapple juice
36. ———

November 5

1. **Banana**
2. Apricot nector
3. **Wheat flakes or farina**
4. **Soft cooked egg**
5. Bacon
6. **Toast**

7. **Cream of asparagus soup**
8. **Melba toast**
9. **Spiced smoked tongue or baked veal cutlets**
10. Broiled beef patties
11. **Scalloped potatoes**
12. Riced potatoes
13. **Kale or green peas**
14. Green peas
15. **Pineapple and grated American cheese salad**
16. **Cream mayonnaise**
17. **Pumpkin pie**
18. Baked custard
19. Strawberry gelatin
20. Unsweetened canned apricots
21. Grapefruit juice

22. **Citrus juice with raspberry sherbet**
23. ———
24. **Beef biscuit roll with gravy**
25. Creamed diced beef
26. Cold sliced beef
27. Potato balls
28. **Quartered carrots**
29. **Lettuce, raw spinach and radish salad**
30. **Vinegar-oil dressing**
31. **Baked apple**
32. Orange sections
33. Baked custard
34. Orange sections
35. Chicken broth
36. **Bread**

November 6

1. **Half grapefruit**
2. Grapefruit juice
3. **Oatmeal or puffed rice**
4. **Poached egg** (omit on Normal Diet)
5. Link sausage
6. **French toast with syrup**

7. **Beef broth**
8. **Saltines**
9. **Scalloped turkey and vegetables or braised breast of lamb**
10. Hot sliced turkey
11. **Shoestring potatoes**
12. Baked potato
13. **Broccoli**
14. Green beans

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Eugene DuPont Memorial Convalescent Hospital, Wilmington, Del.	120
Fort Worth Osteopathic Hospital, Texas	75
Gratiot Community Hospital, Alma, Mich.	86
Hamilton Memorial Hospital, Dalton, Ga.	76
Holy Cross Hospital, Fort Lauderdale, Fla.	136
Home for Aged Lutherans, Wauwatosa, Wis.	75
Johnson County Hospital, Franklin, Ind.	125
Medical Center, Washington, D. C.	200
Milwaukee County General Hospital, Wis.	150
Piedmont Hospital, Atlanta, Ga.	240
Saint Jude's Hospital, Fullerton, Calif.	90
E. G. Williams Hospital, Richmond, Va.	430
Wyoming Valley Hospital, Wilkes-Barre, Pa.	100

CONVERSIONS	No. PT's SERVED BY MEALPACK
Altoona Hospital, Altoona, Pa.	82
Atlantic City Hospital, N. J.	125
Ball Memorial Hospital, Muncie, Ind.	360
Barksdale Air Force Base, La.	116
Burlington Hospital, Burlington, Ia.	150

CONVERSIONS (cont'd)	No. PT's SERVED BY MEALPACK
Connecticut State Hospital, Russell Hall, Middleton, Conn.	105
Cooper Hospital, Camden, N. J.	423
Essex County Sanatarium, Verona, N. J.	100
Gordon Crowell Memorial Hospital, Lincolntown, N. C.	150
Hillcrest Medical Center, Tulsa, Okla.	456
Jane Lamb Memorial Hospital, Clinton, Ia.	100
Kennestone Hospital, Marietta, Ga.	150
Lutheran Hospital, Fort Wayne, Ind.	256
Maxwell Air Force Base, Montgomery, Ala.	250
Memorial Hospital for McHenry County, Woodstock, Ill.	70
Methodist Hospital of Brooklyn, N. Y.	375
Nassau Hospital, Mineola, N. Y.	326
National Naval Medical Center, Bethesda, Md.	48
Norton Memorial Infirmary, Louisville, Ky.	280
Orange Memorial Hospital, Orlando, Fla.	375
Orlando Air Force Base, Fla.	70
Osteopathic Hospital of Kansas City, Mo.	100
Shaw Air Force Base, S. C.	50
Springfield City Hospital, Ohio	150
Suburban Hospital, Bethesda, Md.	75
Swedish Hospital, Seattle, Wash.	384
University of Alberta, Edmonton, Canada	538

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15. **Pear and cranberry relish salad**
16. ———
17. **Orange sherbet**
18. Orange sherbet
19. Orange ice
20. Fresh pear
21. Blended citrus juice

———

22. **Cream of mushroom soup**
23. **Crisp crackers**
24. **Baked Canadian bacon with watermelon pickle**
25. Scrambled eggs with noodles—crisp bacon
26. Baked veal chop
27. Noodles
28. **Asparagus**
29. **Spiced beet salad**
30. **French dressing**
31. **Fruit cup—oatmeal cookies**
32. Applesauce
33. Cherry gelatin cubes
34. Fresh fruit cup
35. Fruitade
36. **Small toasted bun**

November 7

1. **Stewed fruit compote**
2. Blended citrus juice
3. **Crisp rice cereal or brown granular wheat cereal**
4. **Soft cooked egg**
5. Bacon
6. **Bran muffins**

———

7. **Tomato rice soup**
8. **Crisp cracker**
9. **Braised short ribs of beef or club sandwich**
10. Cubed flank steak
11. **O'Brien potatoes**
12. Potato balls
13. **Wax beans**
14. Wax beans
15. **Mixed green salad**
16. **Blue cheese dressing**
17. **Honey rice pudding**
18. Honey rice pudding
19. Lime gelatin
20. Unsweetened canned plums
21. Apricot and lemon juice

———

22. **Turkey gumbo soup**
23. **Saltines**
24. **Shepherds pie with fluted potato crust**
25. Casserole of minced lamb with potato crust
26. Baked lamb patties
27. Baked potato (omit on Soft Diet)
28. **Green peas**
29. **Grapefruit and watercress salad**
30. **Parisian dressing**
31. **Spice cake with lemon icing**
32. Tinted pear and rice compote
33. Vanilla pudding
34. Unsweetened canned boysenberries
35. Grapeade
36. ———

November 8

1. **Tangerine**
2. Orange juice
3. **Farina or wheat and barley kernels**
4. **Scrambled egg**
5. Bacon
6. **Toast**

———

7. **Beef bouillon**
8. **Saltines**
9. **Roast leg of veal with dressing—cranberry sauce or shrimp salad bowl**
10. Roast leg of veal
11. **Oven-browned potatoes**
12. Riced potatoes
13. **Julienne rutabagas**
14. Wax beans
15. **Molded garden salad**
16. **Mayonnaise**
17. **Pineapple chunks—date cookies**
18. Cranberry sherbet
19. Cranberry sherbet (no cream)
20. Fresh pineapple
21. Grapefruit juice

———

22. **Cream of celery soup**
23. **Saltines**
24. **Sauteed liver—French fried onion rings**
25. Baked liver
26. Baked liver
27. Baked sweet potato
28. **Spinach**
29. **Tossed salad**
30. **French dressing**
31. **Chocolate eclair**
32. Canned fruit cup
33. Cream custard
34. Unsweetened fruit cocktail
35. Tomato juice
36. **Cornbread**

November 9

1. **Fresh grapes**
2. Grapefruit juice
3. **Wheat flakes or hominy**
4. **Baked egg**
5. Link sausage
6. **Raisin toast**

———

7. **Cream of spinach soup**
8. **Crisp crackers**
9. **Fried scallops, tartar sauce or baked turkey wings**
10. Broiled whitefish
11. **Hash browned potatoes**
12. Whipped potatoes
13. **Harvard beets**
14. Sliced beets
15. **Cole slaw**
16. ———
17. **Frozen peach shortcake, whipped cream**
18. Peach custard
19. Lemon and lime gelatin cubes
20. Grape and orange cup
21. Tomato juice

———

22. **Broth with vegetables**
23. **Melba toast**
24. **Tuna-potato chip casserole**
25. Fish souffle
26. Low fat tuna on lettuce with lemon wedge
27. Stuffed baked potato
28. **Frozen asparagus tips**
29. **Hearts of lettuce salad with chopped celery and green pepper**
30. **Cream mayonnaise**
31. **Prune whip with custard sauce**
32. Prune whip
33. Soft custard cup
34. Unsweetened canned Royal Anne cherries
35. Blended citrus juice
36. ———

November 10

1. **Orange juice**
2. Orange juice
3. **Rolled wheat or crisp rice cereal**
4. **Poached egg**
5. Bacon
6. **Toast**

———

7. **Cream of corn soup**
8. **Melba toast**
9. **Baked ham—watermelon pickle or baked veal heart**
10. Roast beef
11. **Mashed sweet potatoes**
12. Paprika potatoes
13. **Broccoli with hollandaise sauce**
14. Carrot rings
15. **Cabbage slaw**
16. **Sour cream dressing**
17. **Chocolate pie**
18. Chocolate pudding with whipped cream
19. Whipped raspberry gelatin
20. Pink grapefruit sections
21. Limeade

———

22. **Alphabet soup**
23. **Saltines**
24. **Spaghetti with meat balls**
25. Broiled beef patties—acorn squash
26. Broiled beef patties—acorn squash
27. Spaghetti with tomato puree—acorn squash
28. ———
29. **Mixed green salad**
30. **Vinegar-oil dressing**
31. **Stewed cherry rhubarb—sugar cookies**
32. Whole peeled apricots
33. Apricot nectar sponge
34. Unsweetened canned apricots
35. Pineapple juice
36. **French bread**

November 11

1. **Blended citrus juice**
2. Blended citrus juice
3. **Raisin bran flakes or farina**
4. **Scrambled egg**
5. Bacon
6. **Sweet rolls**

———

7. **Consomme with custard cubes**
8. **Crisp crackers**
9. **Roast beef with brown gravy or cottage cheese fruit plate**
10. Roast beef
11. **Whipped potatoes**
12. Whipped potatoes
13. **French style green beans**
14. French style green beans
15. **Celery and olives**
16. ———
17. **Strawberry ice cream**
18. Vanilla ice cream
19. Orange sherbet
20. Orange sections
21. Grapefruit juice

———

22. **Cream of mushroom soup**
23. **Whole wheat crackers**
24. **Assorted cold cuts—potato salad**
25. Eggs a la goldenrod—green peas
26. Cold sliced lamb—green peas
27. Baked potato
28. ———
29. **Sliced tomato on watercress**
30. ———
31. **Sponge cake**
32. Applesauce
33. Baked custard
34. Fresh pineapple
35. Mixed fruit juice
36. **Rye bread**

November 12

1. **Orange juice**
2. Orange juice
3. **Wheat and barley kernels or hominy**
4. **Poached egg**
5. Bacon
6. **Cinnamon toast**

———

7. **Consomme**
8. **Crisp crackers**
9. **Veal birds with savory stuffing or toasted bacon and tomato sandwich with cheese sauce**
10. Baked veal chop
11. **Creamed potato quarters**
12. Cubed potatoes
13. **Brussels sprouts**
14. Baked acorn squash
15. **Cranberry salad**
16. **Cream mayonnaise**
17. **Chocolate peppermint whipped cream roll**
18. Lime ice
19. Lime ice
20. Unsweetened canned loganberries
21. Grape juice punch

———

22. **Beef vegetable soup**
23. **Saltines**
24. **Ham and cornbread shortcake**
25. Cottage cheese
26. Stuffed tomato with cottage cheese
27. Baked potato
28. **Green beans**
29. **Celery hearts**
30. ———
31. **Royal Anne cherries**
32. Royal Anne cherries
33. Butterscotch pudding
34. Unsweetened canned Royal Anne cherries
35. Fruitade
36. ———

November 13

1. **Applesauce**
2. Grapefruit juice
3. **Oatmeal or puffed wheat**
4. **Soft cooked egg**
5. Bacon
6. **Honey raisin buns**

———

7. **Alphabet soup**
8. **Saltines**
9. **Roast pork or jelly omelet**
10. Hot sliced chicken
11. **Mashed potatoes**
12. Baked potato
13. **Creole celery**
14. Green peas
15. **Red apple and grapefruit section salad**
16. **French dressing**
17. **Peach rice cream**
18. Cherry sponge
19. Cherry sponge
20. Fresh apple
21. Blended citrus juice

———

22. **Creamy potato soup**
23. **Crisp crackers**
24. **Hamburger on toasted bun—pickle ring**
25. Broiled beef patties—sliced beets
26. Broiled beef patties—sliced beets
27. Baked noodles in broth
28. ———
29. **Cabbage, carrot and green pepper salad**
30. **Sour cream dressing**
31. **Frozen cherry cobbler with whipped cream**
32. Whole peeled apricots
33. Vanilla blanc mange with apricot nectar sauce
34. Unsweetened canned apricots
35. Orange juice
36. ———

November 14

1. **Grapefruit sections**
2. Grapefruit juice
3. **Corn flakes or rolled wheat**
4. **Scrambled egg**
5. Broiled Canadian bacon
6. **Toast**

———

7. **Beef bouillon**
8. **Crisp crackers**
9. **Country fried cubed steaks—cream gravy or turkey salad plate**
10. Broiled steak
11. **Mashed potatoes**
12. Whipped potatoes
13. **Spinach with lemon**
14. Spinach with lemon
15. **Pear, cream cheese and currant jelly salad**
16. **Cream mayonnaise**
17. **Coffee ice cream**
18. Coffee ice cream
19. Cranberry sherbet (no cream)
20. Orange sections
21. Orange juice

———

22. **Navy bean soup**
23. **Croutons**
24. **Sausage pattie with candied yams and broiled pineapple slice**

———

25. Creamed turkey in casserole
26. Broiled lamp chop
27. Brown rice
28. **Asparagus tips**
29. **Carrot sticks and celery**
30. ———
31. **Ambrosia with spiced tea cakes**
32. Strawberry gelatin
33. Strawberry gelatin
34. Fresh pineapple
35. Pineapple juice
36. **Cloverleaf rolls**

November 15

1. **Tangerine and grapes**
2. Grapefruit juice
3. **Brown granular wheat cereal or corn flakes**
4. **Poached egg**
5. Canadian bacon
6. **Toast**

———

7. **Beef noodle soup**
8. **Saltines**
9. **Braised pot roast or casserole of noodles Romanoff**
10. Braised pot roast
11. **Oven-browned potatoes**
12. Riced potatoes
13. **Scalloped cauliflower**
14. Sliced beets
15. **Apricot and marshmallow salad**
16. **Sweet French dressing**
17. **Angel food cake**
18. Angel food cake
19. Angel food cake
20. Fresh pear
21. Cranberry punch

———

22. **Cream of tomato soup**
23. **Croutons**
24. **Fricassee giblets with rice**
25. Grilled chicken livers
26. Hot sliced chicken
27. Steamed rice
28. **Quartered carrots**
29. **Chinese cabbage salad**
30. **Pimiento French dressing**
31. **Fruit cup**
32. Canned fruit cup
33. Floating island
34. Fresh fruit cup
35. Apple juice
36. **Bread**

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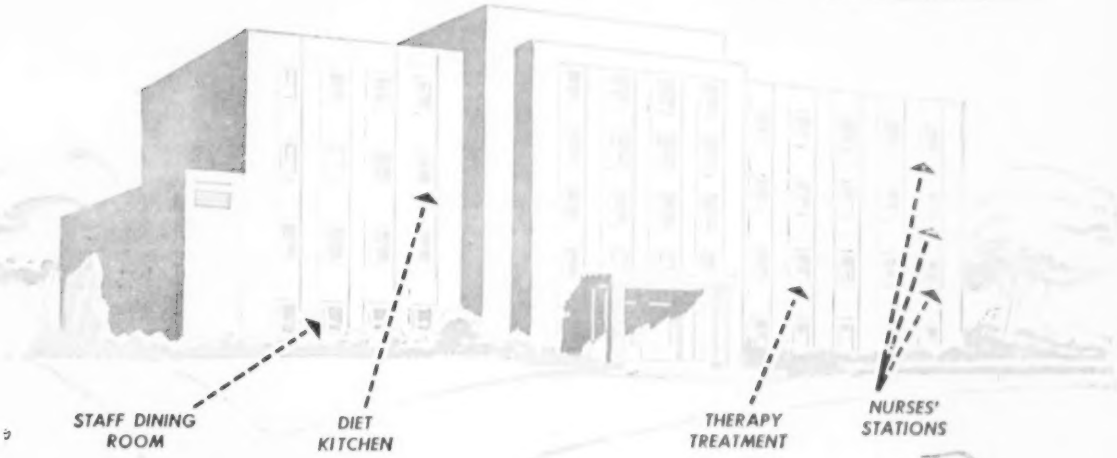
on every floor!



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Warm weather brings heavy ice demands. Now is the time to write for complete information and facts about SCOTSMAN — America's only complete line of ice machines designed and priced for every hospital need.

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We enjoyed meeting the hundreds of you who stopped by our Scotsman booth at the recent Hospital Show. Total attendance at the booth far exceeded our expectations, and we were pleased to have so many opportunities to tell the Scotsman story. Drop us a letter if you would like more information and catalogs. We'll be glad to hear from you!

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purchasing

what to look for in purchasing blankets

by SOL SINGERMAN

The following purchasing outline is the second of a series which will appear from time to time in this department. These outlines are intended to serve as "quick reference" guides for use in the writing of specifications on purchase orders.

A BLANKET, IN its hospital function, should be considered simply as a piece of equipment, used as an insulation barrier to retain warmth for the bed patient.

In choosing a blanket, the purchaser should first determine the conditions under which it will be used and maintained. These local environmental conditions determine the fiber and weight of the blanket.

An important environmental factor is the quality of the laundry. Its equipment, amount of personnel, and space are determinants in the choice of blanket fiber.

Another environmental factor is the type of heating and ventilating used in the hospital. The purpose of a blanket, after all, is to provide warmth. The degree of heat retention necessary to keep the patient comfortable depends upon the heating and ventilation of patient areas. Heating and ventilating systems may vary from outdated systems with extreme seasonal variations to modern air conditioning systems with which room temperature is held close to a comfortable norm throughout the year.

The hospital with extreme temperature variations will need the lightest weight cotton blankets—or even sheets—in the summer and heavy woolen blankets in the winter. The hospital with modern heating equipment, on the other hand, can use one type for year-round service.

The presence of static electricity in some blanket fibers is a third significant environmental factor. The amount of static electricity generated by any particular type of blanket will limit its usage. In the operating room, where static electricity is extremely hazardous and all equipment is designed to reduce it to a minimum, no blankets that produce static can be tolerated. In the patient areas fabrics used under an oxygen tent are dangerous if they are capable of producing enough static to cause combustion. Generally, in all other areas, static generation is not considered important. Research on the hazards of static in hospital areas other than the operating room would be an important contribution to hospital practice.

TYPES OF BLANKET FIBERS

Types of fibers generally used in blankets are as follows:

All wool

All cotton

75% wool and 25% cotton

50% wool and 50% cotton

25% wool and 75% cotton

Synthetics and blends of synthetics with wool and/or cotton.

All Wool. The only wool used in

Size, thickness, weight, breaking strength, and compressibility of blankets

Type	Size (minimum)	Thickness (minimum) (0.1-pound-per-square-inch pressure)	Weight (minimum)	Breaking Strength (minimum) Grab method Warp	Breaking Strength (minimum) Grab method Filling	Compressibility (minimum)
	in.	in.	oz./sq. yd.	lb.	lb.	in. 2/lb.
	60x84	0.260	13	40	30	0.40
I (all wool)	66x90	.260	13	40	30	.40
	72x90	.260	13	40	30	.40
	60x84	.175	10	40	25	.35
II (75% wool)	66x90	.175	10	40	25	.35
	72x90	.175	10	40	25	.35
	45x60	.150	10	40	25	.30
	54x76	.150	10	40	25	.30
III (50% wool)	60x84	.150	10	40	25	.30
	66x90	.150	10	40	25	.30
	72x90	.150	10	40	25	.30

Sol Singerman is director of purchases, Michael Reese Hospital, Chicago.

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any hospital blanket should be long staple virgin wool. All wool blankets provide maximum warmth with minimum weight, and they are the most expensive.

Although the best all wool blankets are treated by fabricating and preshrinkage, the finest will shrink badly if improperly laundered. Water, supplies, temperature, pounding action of the washer, method and temperature of drying —all are contributing factors in wool shrinkage and felting. All wool fibers require the most careful laundering, and therefore, suitable equipment.

Static electricity produced by wool prohibits its use in the operating room. Its use has recently been restricted from oxygen tents as well. These limitations apply to any blanket with wool content.

Flammability of wool is not a major factor, since wool pile fabrics do not melt nor do they have a fast burning rate.

All Cotton. Blankets constructed of cotton fiber retain the least heat per weight and are the least costly. They require no mothproofing and do not create static. Laundering cotton blankets presents few problems, if any. While some shrinkage occurs, it is negligible, under even the poorest laundering processes. In general, it can be said the poorer the laundry facilities, the greater the need for higher cotton content in the fiber.

One-Fourth Cotton, Three-Fourths Wool. A blanket constructed of an all cotton warp (the lengthwise threads) and all wool filler (the crosswise threads) combines many of the advantages of both wool and cotton. The cotton warp will shrink very little, and therefore keeps the blanket from losing its shape. The crosswoven wool filler fibers are constructed relatively loosely so that shrinkage can be absorbed here without reflecting in a marked decrease of the outer dimensions of the blanket. The wool filler provides the maximum amount of heat with the lowest weight. This kind of blanket is less expensive than an all wool blanket.

Half Cotton, Half Wool. These blankets are constructed of all cotton warp with a filler of cotton and wool blend. (Some manufacturers use an all cotton core to these filler yarns, with the outer portion a wool and cotton blend.) The higher cotton content of these blankets greatly reduces the shrinkage problem, and the blankets can be laundered with less critical attention. There is a growing tendency to use this kind of blanket where heating conditions permit. However, the increased cotton content raises the weight of the blanket in relation to its insulating properties.

Three-Fourths Cotton, One-Fourth Wool. The amount of wool contained in these blankets has generally been considered too low to provide any advantages. This mixture is not recommended in the American Hospital Association specifications.

Synthetics and Blends of Synthetics with Wool and/or Cotton. Much discussion has centered around the advisability of using blankets made of synthetic fibers or synthetics blended with natural fibers. The price of an all synthetic material is only slightly less than all wool. There is also some question as to their durability as compared to wool blankets.

Areas of greatest concern regarding synthetics are their high flammability and the high degree of static they generate when they are moved or rubbed. A recent study concluded that it would not be advantageous to use synthetics because of their flammability. Static production in synthetic fabrics is generally extremely high.

On the favorable side, laundering of synthetics presents less of a problem than the laundering of wool. Synthetics shrink much less, if at all, and dry faster, although they must be handled somewhat more carefully than natural fibers. Some synthetics show the highly desirable quality of increased resistance to abrasion, and are therefore included in blends of wool and cotton for this property.

Actually, there has been too little institutional experience gathered concerning synthetic blankets to advise their use. However, synthetics do show great promise for the future.

OBJECTIVE CRITERIA FOR PURCHASING

Written Specifications. An examination of the specifications submitted by many different manufacturers in their advertising shows that they generally adhere to the specifications set up by the Committee on Purchasing of the American Hospital Association, known as Commercial Standard CS136-46. These specifications appear in the accompanying table.

In addition, these specifications should be checked.[1]

1. Color fastness to light
2. Color fastness to laundering
3. Texture before and after laundering
4. Shrinkage
5. Construction of the weave
6. Depth and anchoring of the nap
7. Types of binding (Hemmed and overstitched bindings are preferable for institutional use. Satin or sateen bindings must generally be replaced before the blanket itself is worn out.)
8. Flammability

End-Use Tests. Written specifications in themselves are valuable, but the final criteria must always be end-use tests. A blanket under consideration should be actually used for a time on a bed. The most important end-use test is laundering and drying the blanket at least 10 times.

Price. Price should not be the first consideration in the purchase of a blanket. Only after it has been determined which blanket is the best in terms of patient care and economy should price enter the picture.

SUMMARY

In summary, the selection of the proper blanket fabric for any given area in the hospital depends upon the functional requirements of temperature variations in the patient rooms, laundering, and static electricity tolerance. Only after this analytical decision can the normal purchasing procedures of specification comparison, end-use testing, and price be utilized in the selection of the proper blanket. ■

1. These and additional specifications are included, along with methods of testing, in the American Standard Minimum Performance Requirements for Institutional Textiles (L24). They are available from the American Standards Association, 70 East 45th St., New York 17, N. Y. These publications cover institutional furnishings; utility textiles; uniforms; work clothes; test methods to be used in conjunction with the standards; and permanent labels, detachable tags, and certification of fabrics or products. Publications can be ordered singly; price of the complete set is $6.25. Limited quantities are available for loan from the American Hospital Association.

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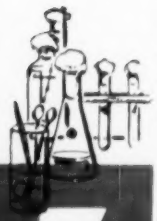
From ENT clinic to the OB ward . . .
all departments find CAROLAB COTTON BALLS
are handy and convenient to use—
completely free of nibs and wispy ends.
They are also an economical substitute
for sponges in many hospital procedures.
The laboratory and dispensary
find that they save time and money.
Cleaning instruments and equipment,
stopping test tubes, bottles and capsule containers,
are all duties which can be speeded up
at lower costs with CAROLAB.



7 reasons why leading hospitals choose CAROLINA COTTON BALLS

1. Uniform in size and shape
2. Firm, compact construction
3. Made of finely spun, selected long staple cotton
4. Highly absorbent
5. Labor-saving—ready for immediate use after sterilization
6. Actually more economical to use than "home-made" cotton balls or other manufactured balls of same high quality
7. Available in 5 standard sizes:

super	2000 per case
special	2000
large	2000
medium	4000
small	8000

special is same size as large but is almost twice as dense

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CAROLAB hospital supplies

HIA HOSPITAL INDUSTRIES ASSOCIATION

Carolina Absorbent Cotton Co.

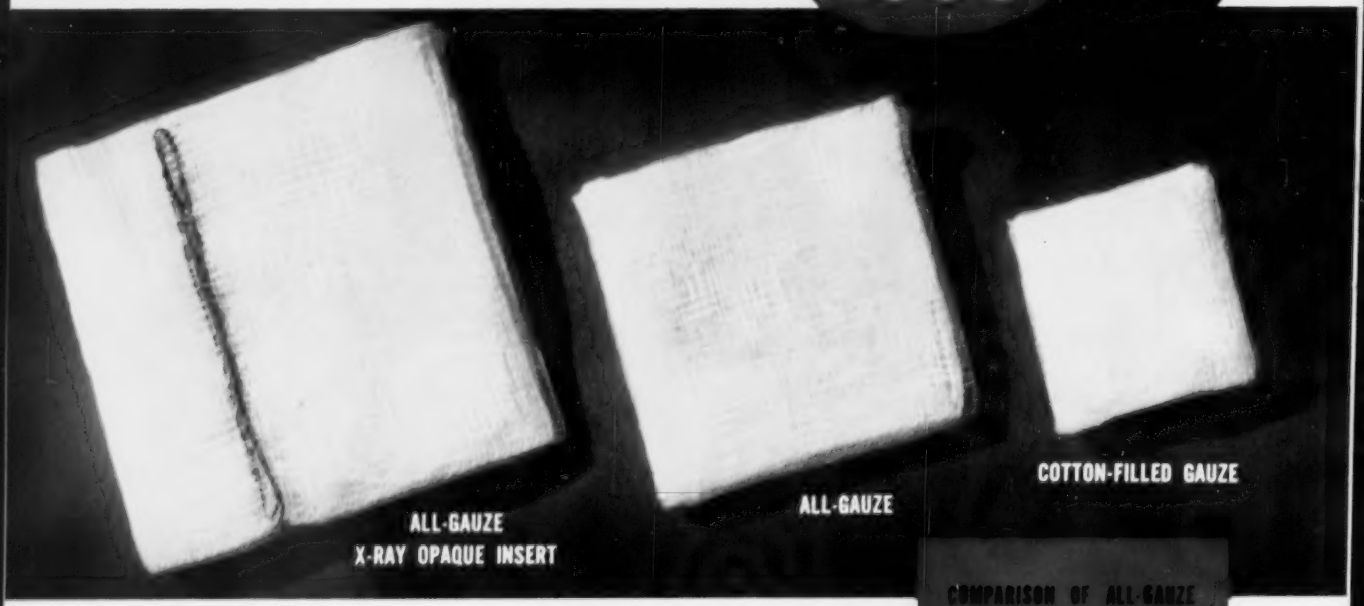
(Division of Barnhardt Mfg. Co., Inc.)
CHARLOTTE 1, NORTH CAROLINA

CAROLINA *Sponges*

3 KINDS

15 SIZES

100's OF USES



Carolina sponges are soft and pliable—absorbent and non-abrasive throughout—no hard or harsh corners. Meticulously made, economical.

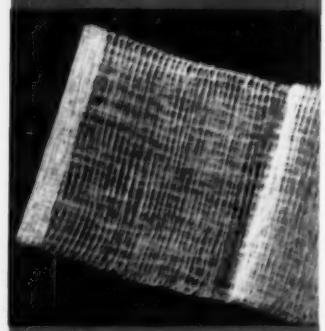
All edges are carefully, neatly folded inside; no loose threads can escape. Carolina sponges are uniform and dependable.

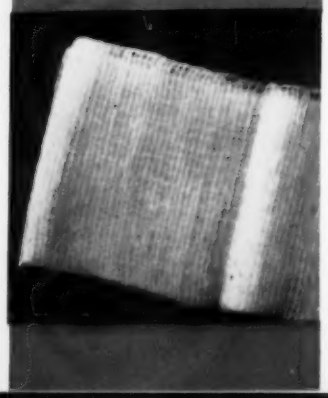
Monofilament X-ray opaque string makes good clear pattern on plates from any angle. Meets hospital standards for safety, ease of use.

For greater economy outside the operating room, substitute Carolina cotton-filled sponges for all-gauze. The thin even layer of combed cotton is very absorbent. Convenient for pressure dressings as well as post-operative dressings and general wound care.

Write for samples, prices, complete information . . .

COMPARISON OF ALL-GAUZE AND COTTON-FILLED SPONGES OPENED ONE FOLD:





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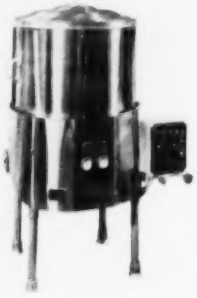
equipment and supply review

Dishwashing machine (19A-1)

Manufacturer's description: Dishwashing machine, including an all-new power rinse unit, is designed with one-piece construction of cylindrical hood and base in 14-gauge stainless steel. The machine has an average operating capacity of 40 racks or 1,400 dishes per hour. The power rinsing, which functions on as little as five pounds of outside water pressure, is con-



trolled by an entirely separate pump built into the rinse reservoir in the base of the machine. Two dish racks and one combination glass and silver rack are supplied as standard equipment with each machine.

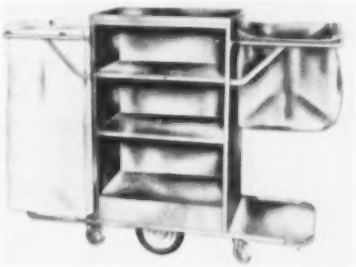
Hospital bed lights (19A-2)

Manufacturer's description: The light shown is one of a new line of adjustable hospital bed lights that adjust to innumerable positions. Most of the models in the line in-

clude a metal shade that remains cool even after hours of use with up to a 100-watt lamp.

Linen truck (19A-3)

Manufacturer's description: Constructed of welded steel, this linen truck features three broad shelves holding more than 25 folded sheets and pillowcases, and an equal quantity



of towels and wash cloths. A choice of six bag types, in white or khaki-colored flame retardant canvas, is available for carrying soiled linen and trash. Two steel platforms, 16 by 20 inches, hold large pails, a vacuum cleaner, trash cans or sweepers. A side rack holds up to five brooms or mops. The cabinet top, 2½ inches deep, holds soap, cleansers, and other supplies.

Stainless steel cookers (19A-4)

Manufacturer's description: Eight models of these stainless steel cookers are available with from one to five individual cooking units. One solid and one perforated three-quart stainless steel pan are furnished as standard equipment for every cooking unit. Only four to five ounces of water are fed to the boiler at each operation. Temperatures reach 15 pounds per square inch at 250° F. in about one min-

An endeavor is made to screen carefully the products appearing in this section. However, the statements printed have been made by the manufacturer and are brought to your attention primarily to keep you informed of new developments in the field. —The Editors.

ute. The self-sealing door is the same safety door featured in steam pressure autoclaves used in the medical and dental professions. The cooker is installed by connecting it to a 3-phase, 220-volt power supply, to a water line and to an accessible drain.

Disposable otoscope specula (19A-5)

Manufacturer's description: The disposable specula permit a doctor to use

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▶ To learn the names and addresses of manufacturers of products and distributors of literature described in this review, check the appropriate items on this coupon, sign your name and address, clip and mail to the Editorial Department of HOSPITALS, J.A.H.A., 18 E. Division St., Chicago 10, Illinois.

☐ Please send my name direct to the manufacturer.
☐ Please send the name of the manufacturer to me.

PRODUCT NEWS

____ Dishwashing machine (19A-1)
____ Hospital bed lights (19A-2)
____ Linen truck (19A-3)
____ Stainless steel cookers (19A-4)
____ Disposable otoscope specula (19A-5)
____ 22-gallon trash can (19A-6)
____ Automatic door operator (19A-7)

PRODUCT LITERATURE

____ Maintenance work planning guide (19AL-1)
____ Conveyor and pneumatic tube systems (19AL-2)
____ Laboratory carts (19AL-3)
____ Specialized laundry equipment (19AL-4)
____ Vitamin C booklet (19AL-5)
____ Face brick (19AL-6)
____ Insect control (19AL-7)
____ Rehabilitation products catalog (19AL-8)
____ Radio-pharmaceuticals price list (19AL-9)
____ Sweeping and mopping manual (19AL-10)

NAME and TITLE _____
HOSPITAL _____
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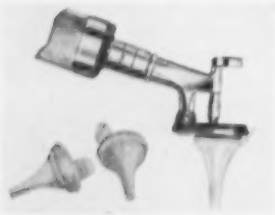
(Please type or print in pencil)

a speculum once, discard it and replace it instantly with a fresh one. The disposable specula are made of a specially developed white, chemical resistant plastic, and are packed in transparent push-up tubes holding 40 "specs." The specula are pressed into place over a special permanent inner speculum and the otoscope is ready for



use. A slight pull on the removal tab instantly strips off the used speculum.

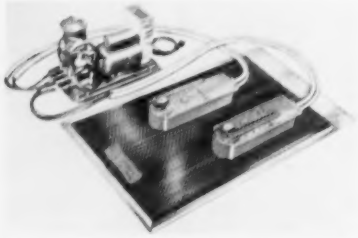
22-gallon trash can (19A-6)

Manufacturer's description: Break resistant, nonrusting, lightweight and easy-to-clean, this 22-gallon plas-

tic trash can comes in green, red, gray, or yellow, with a black top. The lid locks in place under molded-on lugs. If the can is knocked over, contents will not spill out. The lid, however, can be unlocked with a slight twist. The plastic material resists water, oil, grease, alkalies and acids. Clinging refuse can be quickly hosed out. Price is approximately $13.

Automatic door operator (19A-7)

Manufacturer's description: A new line of concealed, noiseless door operators, six of which are carpet-actuated and two handle-actuated. A larger and sturdier hinge, a new type molded mat and a simplified heavy-duty power unit are the main design changes. Among safety features of the device: doors always open away from persons entering; doors will not open if a person is standing in way of door's swing; if power fails, doors will



operate manually; there is a panic breakaway to convert "in" doors to "exits" in emergencies

product literature

(SEE COUPON ON PAGE 101)

Maintenance work planning guide (19-AL-1)—This new work planning guide provides a day-to-day schedule of work for the maintenance crew. The planning guide consists of a wall hanger type folder containing 90 daily work sheets. These sheets provide for (1) designation of work area, (2) individual job assignments, (3) employees to whom jobs are assigned, (4) additional or special assignments not listed on the form, and (5) a checking column for jobs completed. The back page of the folder contains suggestions for care of several types of flooring material.

Conveyor and pneumatic tube systems (19AL-2)—Pneumatic tube systems, food service conveyors, and central vacuum cleaning systems are fully explained and illustrated in this new catalog.

Laboratory carts (19AL-3) — This brochure describes a line of laboratory carts that includes portable tables, glassware carts, pan-type carts, a portable instrument desk, tote box cart, and a flask carrier cart.

Specialized laundry equipment (19-AL-4)—A 12-page illustrated catalog describes specialized laundry equipment. Engineering data describing each product, its operation, installation and assembly is included, together with weights, sizes, and capacities of the various types and models. Described are a lint collector, circulating soap system, and washing machine loading hopper.

Vitamin C booklet (19AL-5)—A new edition of a booklet on citrus fruits in health and disease. It includes a new section on stress and the general adaptation syndrome, covering the role of vitamin C in stress. The booklet contains references to 160 authoritative medical papers on such subjects as acne, miscarriage, obesity, and natural vs. synthetic vitamin C.

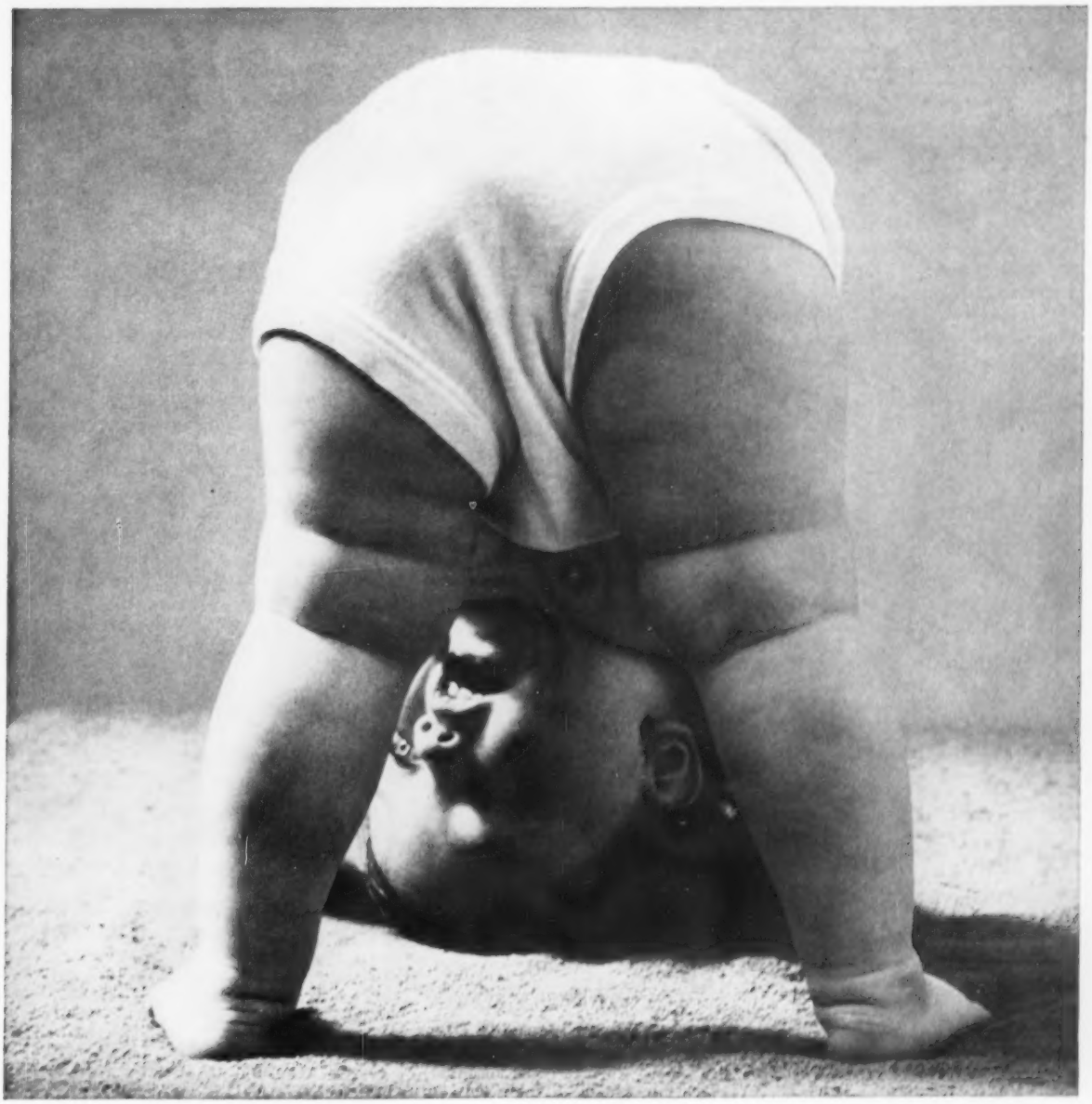
Face brick (19AL-6) — This 32-page full color brochure shows applications of this line of face brick now being produced in new colors and pastel shades. Bonds and mortars are discussed as well as various types of approved joints.

Insect control (19AL-7)—Information on electric control of flying insects addressed to maintenance and dietetic departments of hospitals. Detailed suggestions on specific control problems are available without obligation.

Rehabilitation products catalog (19-AL-8)—This 150-page catalog is purported to be a complete source for rehabilitation and physical therapy equipment. More than 750 products are illustrated and detailed.

Radio-pharmaceuticals price list (19-AL-9)—A 10-page catalog of radio-pharmaceuticals and new products. The catalog also lists auxiliary solutions and equipment.

Sweeping and mopping manual (19-AL-10)—This 24-page manual is filled with simple "how to" explanations and illustrations. In a newly revised edition, the manual is based on careful job analysis and extensive scientific research. It shows the best and quickest ways to sweep and mop all types of floors.



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personal news

• REBECCA CHRISTOPHER, R.N., has been appointed administrator of the Gaston Hospital, Dallas, Tex. She was formerly director of nursing services at Mount Sinai Hospital, Cleveland, Ohio.

• HOWARD F. COOK has been appointed administrator of Community Hospital, Evanston, Ill. He succeeds WILLIAM R. HOWES.

Mr. Cook has been secretary of the Council on Association Services of the American Hospital Association since 1954. He came to the Association in July, 1950 as secretary of Association development. He has also served as secretary of the housekeeping and laundry committees.

Mr. Cook is a graduate of the Northwestern University program in hospital administration and received his master's degree with distinction.

Just prior to joining the AHA, Mr. Cook was administrator in charge of Children's Hospital, State University of Iowa Hospitals in Iowa City.

MR. COOK

MR. ROLLINS

• JOHN D. ROLLINS has been appointed administrator of the Ontonagon (Mich.) Memorial Hospital. He is a graduate of the University of Minnesota course in hospital administration and served his residency at St. Luke's Hospital, Milwaukee.

WILEY E. MIDDLETON has been appointed administrator of Polk County Memorial Hospital, Mena, Ark. He succeeds WALLACE W. FAVORITE.

• KENNETH A. RINDFLESH has been appointed administrator of Ventura (Calif.) County General Hospital. Mr. Rindflesh was formerly director of Salt Lake County General Hospital. He succeeds LYLE WALTERS who retired July 1.

Mr. Rindflesh is a graduate of the University of Minnesota course in hospital administration.

• SISTER GRACE MARIE HILTZ, S.C., R.N., has been appointed administrator of St. Mary-Corwin Hospital, Pueblo, Colo., succeeding

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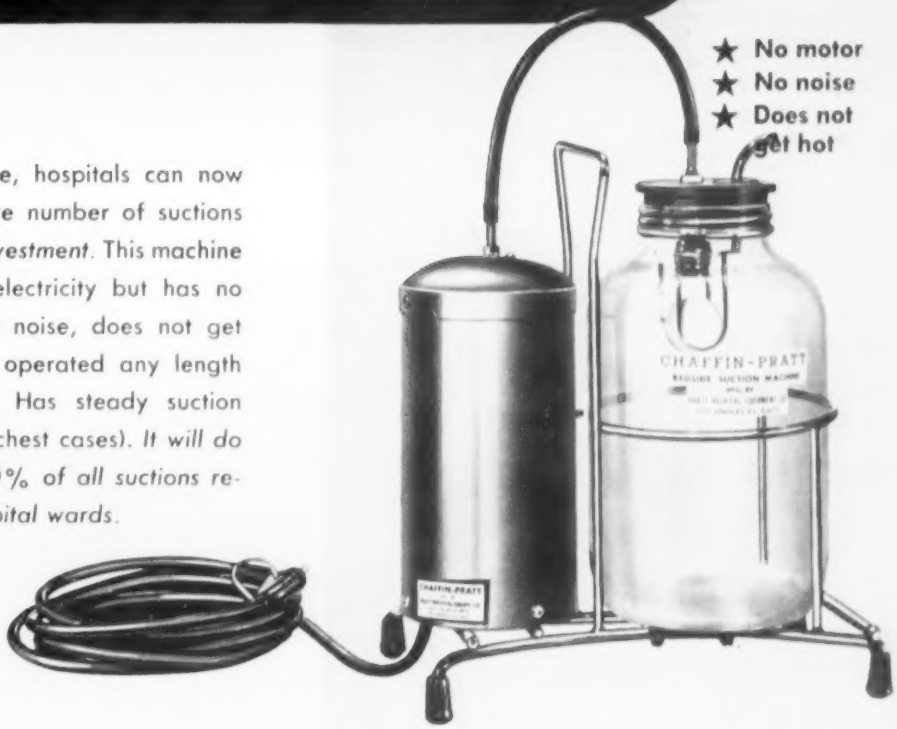

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SISTER HELEN EUGENE, S.C. Sister Grace Marie was formerly assistant administrator of Good Samaritan Hospital, Dayton, Ohio. She is a graduate of the St. Louis University course in hospital administration.

Sister Grace Marie will be responsible for closing both St. Mary and Corwin Hospitals and opening a new 450-bed St. Mary-Corwin Hospital.

• SISTER MARY MAURELIA, C.S.S.F., has been appointed administrator of Blackwell (Okla.) General Hospital, Sister Maurelia is a graduate of the St. Louis University course in hospital administration.

• SISTER M. GERTRUDIS, O.S.F., has been appointed administrator of St. Francis Hospital, Evanston, Ill. She succeeds SISTER M. STEPHANINA, O.S.F., who has been elected assistant to the Mother Provincial by members of the Community of St. Francis.

Sister Gertrudis was formerly assistant administrator of the hospital and director of the school of nursing.

• TALMAGE D. SMITH JR., has been appointed administrator of Roosevelt General Hospital, Portales, N. M. He succeeds THOMAS J. HARTFORD JR.

Mr. Smith was formerly assistant administrator of Clovis (N. M.) Memorial Hospital. He is a graduate of the Northwestern University program in hospital administration.

• ABBIE E. DUNKS has been appointed to the newly created position of administrator of the Boston Dispensary, a unit of the New England Medical Center. Miss Dunks has been director of the Dispensary since 1950.

She is a member of the Board of Trustees of the American Hospital Association.

MISS DUNKS

DR. WAINE

HANS WAINE, M.D., also has been appointed to a newly created position, that of chief of staff of the Boston Dispensary. Dr. Waine has held positions in academic, investigative and administrative medicine, both in Boston and San Francisco. Dr. Waine's position will include correlating the various medical services of home medical care, clinic service and rehabilitation.

• W. ALLEN WALTON has been appointed administrator of Memorial Hospital, Philadelphia. He succeeds HARRY J. RODGERS.

Mr. Walton has been office manager and comptroller of Memorial Hospital for the past 10 years.

Deaths

• HARRY ROSWELL WAHL, M.D., for many years pathologist and superintendent of the University of Kansas Hospitals, Lawrence, died June 18, aged 70.

In recognition of his services, the Kansas Board of Regents recently decided to change the name of the Medical Science Building at the Medical Center to Wahl Hall.

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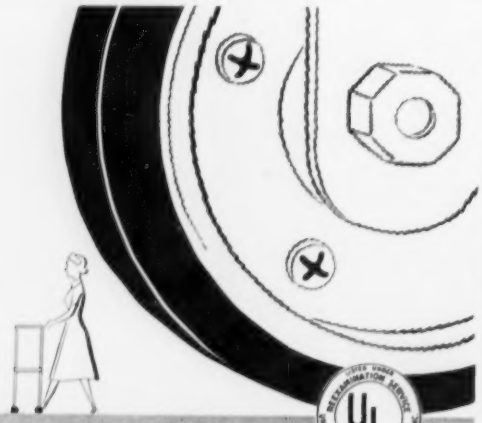

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THE HOSPITAL COUNCIL OF GREATER NEW YORK here reports in full upon a study of organized plans existing in New York City for extending comprehensive medical care to the long-term patient in his home. This study is believed to be the most extensive investigation of home medical care programs thus far published and the only one that examines such programs not only from the standpoint of those rendering services to the patient, but also from that of the social, economic, emotional, and domestic—as well as physical—needs of the patient and his family. Its analysis and evaluation of the existing New York City programs and its suggested standards for establishing and operating new programs are more detailed and concrete than any previously published.

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THE COMMISSION ON CHRONIC ILLNESS here presents the first publication in a four-volume series on *Chronic Illness in the United States*. This book provides a fundamental study of the care of the long-term patient in both home and institution. Who is the long-term patient, where is he, what kinds of care—physical and mental—does he need, and how and where should these services be provided? What about rehabilitation—at home and in the institution? What institutions take care of long-term patients, and how well do they do so? What kinds of personnel are needed and how should they be trained? How about problems of coordination and integration of services, of research, of finance? This book provides a comprehensive, authoritative discussion of all these basic questions about the care of the chronically ill.

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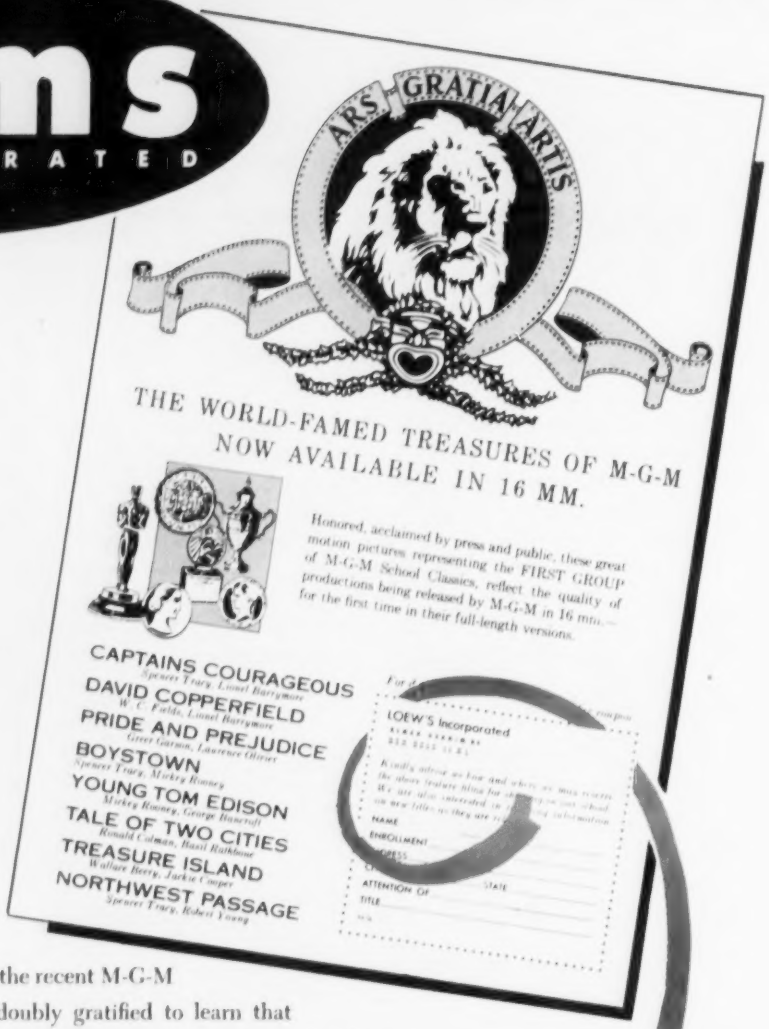

INSTITUTIONS who welcomed the recent M-G-M announcement reprinted above will be doubly gratified to learn that Films Incorporated has been chosen as the exclusive 16mm distributor for these world-famed M-G-M features and short subjects. . . . The eight films listed above are but a sample of the more than 250 M-G-M feature classics *immediately available* to you . . . they are listed in the new Films Incorporated M-G-M catalog supplement now off the presses. . . . For first choice of subjects and booking dates, be sure to fill in the coupon below. Mail today for your advance copy of this complete list of M-G-M subjects . . .

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Washington Report

- *Advisory Groups Named*
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Department of Health, Education, and Welfare Secretary Marion B. Folsom has appointed a committee to study and develop methods of adapting hospital facilities and services more closely to the varying needs of patients. The committee will seek ways of reducing hospital operating costs and improving care for hospital patients who need only limited services.

Dr. Russell A. Nelson, director Johns Hopkins Hospital, Baltimore, was appointed chairman of the new committee, the Advisory Committee on Hospital Facilities and Services.

DR. NELSON

Other members of the advisory committee are: Ray E. Brown, superintendent, University of Chicago Clinics, and American Hospital Association past president; Dr. Robert Elman, department of surgery, School of Medicine, Washington University, St. Louis; Charles G. Roswell, hospital accountant, Montclair, N. J.; Ruth Sleeper, R.N., director, School of Nursing and Nursing Service, Massachusetts General Hospital, Boston, and Marion J. Wright, director, Jennings Memorial Hospital, Detroit.

To assist the committee, the Public Health Service already is collecting detailed information on work done so far in developing or operating facilities in keeping with varying patient needs. The AHA and the American Institute of Architects, which have councils on hospital planning will be asked to cooperate.

PHS officials explained that the committee will consider, for example, possibilities for developing hospital units in which patients could provide more services for themselves. Many patients might be able to go to a cafeteria or dining room for their meals, thereby reducing the costs of food distribution. Some might be able to do light housekeeping in their rooms, officials said.

The committee will also consider the feasibility of using rooms designed for patients who would be hospitalized only at night, or only during the day, or for limited hours during the day or night. This could fit the needs of persons, for example, who chiefly need diagnostic services, or those who can obtain adequate care in their homes part of the time. Many patients who need only part-time hospitalization must now pay for hospital services on a 24-hour basis.

Medical Research Grants

A 12-member advisory council has been appointed by Department of Health, Education, and Welfare Secretary Marion B. Folsom to assist the Public Health Service in administering the federal grants for construction of medical research facilities.

The advisory council, established in the law authorizing $90 million in matching federal funds, will be known as the National Advisory Council on Health Research Facilities. The council met Sept. 24-25 to review initial applications for aid from research hospitals and other institutions.

The surgeon general (chairman) and an official of the National Science Foundation are *ex officio* council members.

Named by Secretary Folsom were:

Dr. George N. Aagaard, professor of medicine and dean of the School of Medicine, University of Washington, Seattle; Eugene N. Beesley, president of Eli Lilly and Company, Indianapolis; Dr. Thomas H. Hunter, dean of the School of Medicine, University of Virginia, Charlottesville; Dr. Carlyle Jacobsen, executive dean for medical education, State University of New York, Delmar; Dr. Paul C. Kitchin, professor of dental histology and embryology of the School of Dentistry, Ohio State University, Columbus, and Dr. Oliver H. Lowry, dean of the School of Medicine, Washington University, St. Louis.

Also Dr. Robert A. Moore, vice chancellor, University of Pittsburgh; F. C. Sowell, vice president and general manager of radio station WLAC, Nashville, Tenn.; Dr. John E. W. Sterling, president, Stanford (Calif.) University; Dr. Thomas B. Turner, professor of microbiology of the School of Hygiene and Public Health, Johns Hopkins University, Baltimore; Dr. James W. Wilson, professor and chairman of the department of biology, Brown University, Providence, R. I., and James B. Mintener, who has announced plans to resign as assistant secretary of HEW.

Dependent Medical Care

The Department of Defense has announced that Major General Paul I. Robinson will be its administrator for the program of aid to civilian dependents of military personnel. The Department of the Army has been designated the contractual agent for all the armed forces.

GEN. ROBINSON

At a recent Washington meeting, the Department of Defense advisory committee on the civilian hospital and medical care part of the program outlined regulations for carrying out its current plans which have to be approved by Defense Secretary Charles E. Wilson.

Present plans, subject to change, call for contractual arrangements with insurance companies to serve as fiscal intermediaries—handling payments to hospitals—in the Middle West and plains states, corresponding to the Fourth and Fifth

(Continued on page 120)

TRANSFUSION CASE—

N. Y. Court Rules on Hospital Liability

New York State's highest court, the Court of Appeals, has ruled that a hospital is liable for the negligent acts—even though they are "medical acts"—of its nonprofessional employees.

The court thus reversed a finding of a lower appellate court that the hospital was not liable for the negligence of a laboratory technician in mistakenly reporting a blood type, with a resultant transfusion reaction. The Court of Appeals reinstated the verdict of the trial court, awarding a total of $20,202.25 damages to the plaintiff. The defendant was the New York Society for the Relief of the Ruptured and Crippled.

In its unanimous opinion, the court of Appeals raised, but said it did not have to decide, the question of whether hospitals should be liable for acts performed by professionals (physicians and nurses) who "are salaried members of the hospital's personnel rather than outside professionals called in to minister to patients . . ."

"Modern hospitals," the opinion said, "hire on salary not only clerical, administrative and housekeeping employees but also physicians, nurses and laboratory technicians of many kinds. Not only do they furnish room and board but they sell services which are 'medical' in nature and though furnished on physicians' orders are performed wholly by and under the control of the hospitals' salaried staffs.

"What reason compels us to say that of all employees working in their employers' businesses (including charitable, educational, religious and governmental enterprises) the only ones for whom the employers can escape liability are the employees of hospitals?"

The trial court held that the act of the technician was an "administrative" act and thus the hospital was liable.

The Appellate Division (the first step in New York's appeal procedure) reversed the trial judge and stated that the criterion was the nature of the alleged act of negligence, not the title of the person performing the act.

The Appellate Division ruling (with one dissent) held that if the act were immediately and integrally related to the medical care and treatment prescribed for the patient, then the act of negligence, no matter how simple or how far removed from the common concept of a professional act, was "medical" in nature and the hospital was, therefore, immune from liability.

The dissenting opinion stated that there was no warrant to preclude hospital liability for a negligently administered or negligently reported blood test:—(1) performed by hospital employees of subprofessional status; (2) in a laboratory maintained exclusively under the supervision of the hospital, and (3) over which the attending physician had neither direction nor responsibility.

From the viewpoint of the hospital, the dissenting judge held, this case was not an instance of facilities provided for the professional performance of his responsibility by the attending physician. This was an administrative failure by the hospital, following or preceding a medical prescription in the same way as the placing of sideboards which had been ordered by the physician, or the giving of the right blood to the wrong patient.

The dissent in the Appellate Division entitled the plaintiffs in the original case to carry their claims to the highest appellate level, the Court of Appeals.

Emanuel Hayt, counsel for the Hospital Association of New York State, called the decision one of "great importance," in an analysis published in the August 1956 issue of the Association's monthly bulletin.

Mr. Hayt said the Court of Appeals decision would seem to limit the hospitals' liability exemption to professional acts of negligence "by physicians and nurses. A technician does not have professional status and is not given the same recognition as physicians or nurses.

"Although the making of a blood test is a medical act, its performance by a technician does not convert the technician into a professional person. On the other hand, the performance of such a test by a nurse or a physician would appear to give the act professional status."

"It may be concluded," Mr. Hayt said, "that a hospital is liable for the errors of a technician irrespective of whether the act is medical or administrative, because of the lack of professional status of the technician . . . "

He noted that the court avoided a decision as to whether the hospital would be liable for the negligent medical acts of salaried physicians and nurses.

Experts Hold Round Table

DR. ALBERT W. SNOKE, president of the American Hospital Association, was a participant in a round table discussion broadcast Sept. 23 by the National Broadcasting Company. Panel members were (from left): Dr. Snoke, Dr. Lowell T. Coggeshall, special assistant for health and medical affairs, Department of Health, Education, and Welfare; Arthur Snider, science editor of the *Chicago Daily News*, and Edward W. Rosenheim Jr., University of Chicago, who acted as moderator. The program was part of NBC's *New World* series.

Mary Schabinger Honored

Mary C. Schabinger, a trustee of the American Hospital Association and administrator of Detwiler Hospital, Wauseon, Ohio, was made a Lady of the Equestrian Order of the Holy Sepulchre of Jerusalem, by her church in St. Patrick's Cathedral, Sept. 15. The honor is conferred upon distinguished members of the Roman Catholic laity.

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IN ONTARIO, CANADA—

Court Rules 'Fee Splitting' Ban Valid

Ontario, Canada's Supreme Court has ruled that the governing board of a public hospital is justified in requiring an audit of the books of its medical staff members in order to prohibit "fee splitting."

Three practitioners on the medical staff of Victoria Hospital, London, Ontario, sued the board of trustees in an attempt to nullify a bylaw (the "Columbus Plan") of the hospital by having the bylaw declared beyond the purview of the board's legal field of activity.

The bylaw reads: ". . . All books of account of such physician or surgeon shall be open for inspection at any time, but not less frequently than once each calendar year, to an auditor appointed for the purpose by the board of trustees, who shall report to the board of trustees, or to such person or committee as it may from time to time designate, and such report shall only indicate whether or not such physician or surgeon has complied with the provisions of this bylaw . . .

"If it is reported that such physician or surgeon has not complied with the provisions of this bylaw, the board of trustees may deny the privileges of attending patients in and/or the use of the facilities of Victoria Hospital to such physician or surgeon."

During the course of the hearing, the hospital declared that fee splitting created a problem for the hospital and the board had to deal with it. "The question," the court opinion said, "is whether in attempting to do so it has exceeded its powers . . ."

According to the plaintiff's testimony, the court said, ". . . The bylaws, or at least the disputed provisions in them, go too far . . . because the board has no jurisdiction over the medical profession as such, and hence no right to discipline a physician or a surgeon." The court then said, "but the general bylaws clearly apply only to medical practitioners who are members of the medical staff of the hospital."

The court also cited Section 5 of the City of London Act, 1954, Cap. 115 which dealt with Victoria Hospital and another London hospital and which, in the court's words ". . . would seem to apply to all members of the medical profession, as well as all others, who make use of the hospital."

The section cited by the court says: ". . . The said board is empowered to enact bylaws and regulations subject to the Public Hospital Act and not inconsistent with this act for the regulation and organization of the said board and for the management, operation and control of the said hospitals and the use thereof, and *to which last mentioned bylaws and regulations all persons making use of the said hospitals, or either of them, shall conform.*" (Italics supplied by the court.)

The court also said ". . . the force of the broad powers implicit in the words 'govern' and 'manage' and 'control' [mentioned elsewhere in the City of London Act, 1954] is recognized by [the plaintiff's attorney] but he contends that they do not authorize a board to prohibit medical practitioners from using the facilities of the hospital . . ."

Action taken by the board in the

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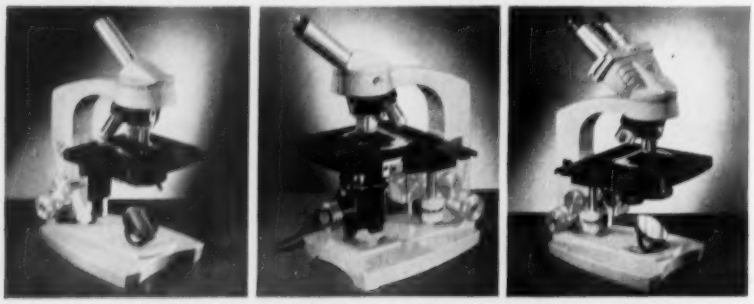

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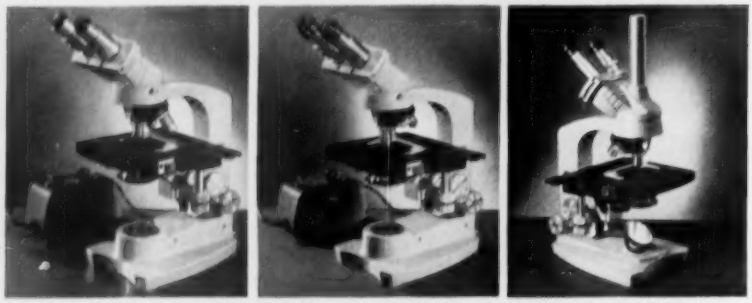

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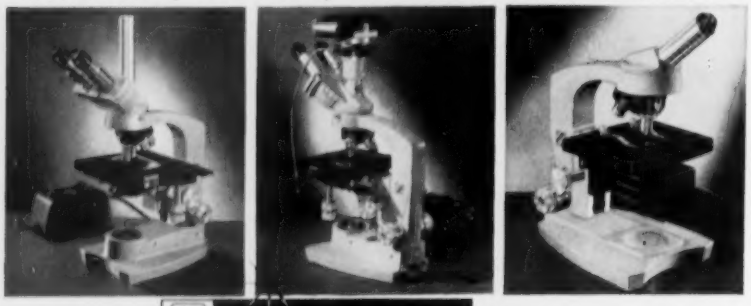

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City State

form of the disputed bylaw was termed "positive," "regulatory," and "not prohibitive," by the court.

"The new bylaw needed to have teeth in it . . . the medical staff had to be disciplined where necessary," the court found.

In its decision the court further said: ". . . The principle is well established that a statutory power to pass bylaws carries with it the implied power to impose reasonable penalties for their infraction; otherwise the bylaws would be largely nugatory . . . For the reasons stated I am satisfied that the . . . bylaw is valid and binding upon the members of the medical staff of Victoria Hospital . . . The plaintiff's action . . . is . . . dismissed."

American Hospital Association Appoints Johnson, Willcox

Dr. Edwin L. Crosby, director of the American Hospital Association, has announced the following staff appointments:

Alanson W. Willcox to be the Association's general counsel.

Richard L. Johnson to be secretary of the Council on Administrative Practice.

Mr. Willcox is now a legal con-

MR. WILLCOX

MR. JOHNSON

sultant in Washington, D.C., and Mr. Johnson is superintendent of the University Hospital, Columbia, Mo.

Dr. Crosby said:

"I am delighted to announce these new appointments. The need for much greater work by the Association in legal matters has long been recognized. Mr. Willcox will maintain his office in the Washington offices of the Association but he will be concerned with legal matters at all levels which affect hospitals.

"Mr. Johnson is well known in the hospital field and brings many years of actual practice in hospital administration to his new position."

Mr. Willcox is a graduate of Cornell University and the Harvard law school. He practiced law in New York for eight years. He has

NEW TOLEDOS

streamline kitchen service in BIG BROMLEY Ski Area RESTAURANT

A warm welcome, fun and fine food await guests at Big Bromley Ski Area Restaurant, hugging the snow clad slopes of Vermont's Big Bromley Ski Area near Manchester Center.

This well-managed restaurant speeds kitchen operations and food service with efficient, labor-saving Toledos. Ample supplies of sparkling-clean dishes and tableware are provided by a Toledo Conveyor Dishwasher with Pre-Wash. A new Toledo Slicer with illuminated platter and gravity feed makes short, easy work of slicing chores . . . is super-safe to clean. And fast, double action peeling that goes just "skin deep" is routine, thanks to a new Toledo Peeler.

It will pay you to check on new Toledos for your kitchen, too. We'll gladly send you the latest information without obligation. New catalogs on dishwashers, peelers, disposers and food machines are ready. Write for those that interest you.

A Toledo Dishwasher, Slicer and Peeler help Big Bromley Ski Area Restaurant maintain high standards of kitchen service with important savings in time and labor. Installation by Thompson-Winchester Co., Inc., Boston, Mass.

SERVICE Factory-Trained 200 Cities

TOLEDO SCALE COMPANY

Kitchen Machine Division
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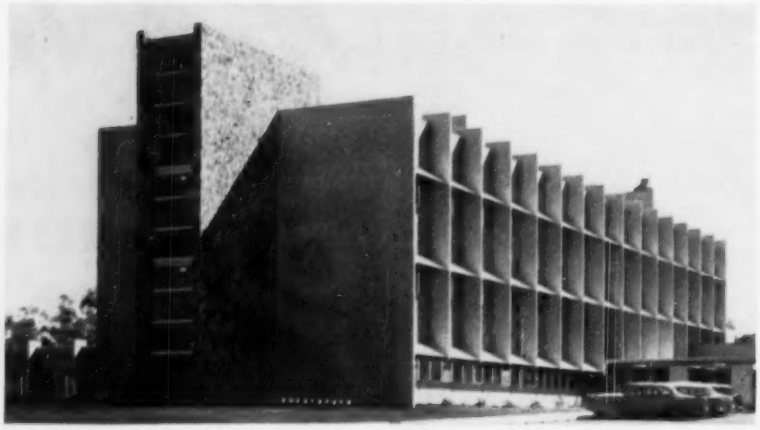
been in various government legal positions for many years, including service from 1947 to 1953 as general counsel of the Federal Security Agency.

Mr. Johnson is a graduate of Northwestern University and of the University of Chicago course in hospital administration. He was a member of the Association staff in 1950 and 1951 and then went to the University of Chicago Clinics as assistant superintendent and associate director of the graduate course in hospital administration. He took the University Hospital post in Columbia in 1955.

He succeeds Ann S. Friend as council secretary. Mrs. Friend resigned for personal reasons of health, having been ill for much of the past six months.

Hospital Opens in California



GROSSMONT HOSPITAL, La Mesa, Calif., began operating in mid-August, administrator L. M. Peelyon, reported. The hospital, costing $1.7 million, has 105 beds, 42 surgical, 39 medical and pediatric, and 24 maternity. Seven major surgery rooms are available, including emergency, general surgery, orthopedic, cystoscopic, and delivery. There is also an oral surgery room. Grossmont, whose columnar cantilever construction and movable walls permit expansion of its facilities, is in the process of adding 80 beds.

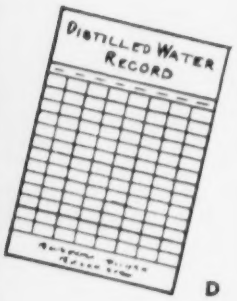
Oregon Supreme Court Rules Hospitals Must Prove Charity

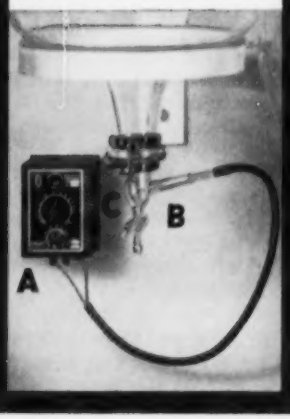
Juries hearing cases in which hospitals are defendants should determine whether the hospitals are charitable, nonprofit operations, if their claims to be such are challenged by the plaintiffs, according to a recent decision of the Oregon Supreme Court.

James G. Swindells, attorney for the Oregon Association of Hospitals, said that "in effect the court holds that the mere fact that a hospital is organized under Oregon statutes that are intended to create charitable, nonprofit corporations is not necessarily controlling."

The jury hearing the case of Ackerman vs. Physicians and Surgeons Hospital last year found the hospital was not charitable, but the finding was challenged and the case was carried to the state Supreme Court which originally sustained action setting aside the jury's verdict.

NEW: BARNSTEAD PMB-25 provides a simple, more effective control procedure for Safeguarding Distilled Water Purity





THE BARNSTEAD Test Set No. PMB-25 makes it easy to test distilled water each day right in the hospital and to keep record of test results. It is designed for use with Pyrex distilled water storage tanks and provides a low-cost permanent installation that permits quick testing of distilled water purity. In fact, this Barnstead test is so simple that it requires scarcely 30 seconds to perform because the test equipment is always in place and ready for use. And with it, you get a test sheet, signed by the technician, as a permanent record of test result for your files. The initial cost is low and you do not have to buy expensive recording equipment.

As sketched, the complete test set consists of (a) a Barnstead Purity Meter, (b) a conductivity cell in storage tank outlet, (c) a special Pyrex stopcock with side opening to accommodate the cell, (d) a pad of charts for recording test results. The special stopcock containing cell will replace stopcock in Pyrex tanks now in service. The meter can be wall mounted at any convenient point adjacent to tank.

Bulletin #138 describes test procedure. Write for your Copy.

Barnstead STILL & STERILIZER CO.

27 Lanesville Terrace, Boston 31, Mass.

The Supreme Court has now reversed itself saying that a jury may hear evidence on a hospital's charitable status so as to determine the hospital's immunity from judgments for damages due to neglect by employees.

In commenting further on the decision Mr. Swindells said that "this decision does not mean that the immunity rule to charities in Oregon does not still stand, but it is an important decision in that it points out that if a hospital states that it is charitable and if the plaintiff denies that it is, then the hospital has the burden of proof in asserting such a defense . . . The acts and deeds and activities of the corporation will be examined to determine whether in truth and in fact it is charitable."

American Hospital Association Has 6,888 Members on Aug. 31

As of Aug. 31 the American Hospital Association showed a net gain of 263 members over the same date last year. The total membership was 6,888, according to recently released figures.

There were 5,387 Type I and II members on Aug. 31 of this year, a net gain of 165 over the previous year. There were 1,146 Type V members as of Aug. 31, 1956, a net gain of 102 over the same time last year.

Personal membership figures, as of Aug. 31 of this year, showed a total of 4,321 members, a net gain of 318 over the same date last year.

On Aug. 31, 1956, there were 3,084 Type A members, 879 Type B, 48 Type C, 242 life members, and 68 honorary members.

Marion Foster Appointed North Carolina Secretary

Marion J. Foster has been named the first full-time executive secretary of the North Carolina Hospital Association, effective Oct. 16, C. D. Ward, NCHA president, announced last month.

MR. FOSTER

Mr. Foster is to put a full-time Association program into effect for NCHA. The headquarters office is to be established in Raleigh.

Mr. Foster, a member of the bar in Virginia and Washington, D.C., received his law degree from George Washington University, Washington, and a master's degree in law from the National University School of Law, Washington.

He was legislative assistant in the American Hospital Association's Washington Service Bureau from 1951 to 1955, when he assumed his present position as staff attorney with the Association.

Blood Bank Association Names Muirhead President

Dr. E. E. Muirhead, professor and chairman of the department of pathology, University of Texas Southwestern Medical School, Dallas, was named president of the American Association of Blood Banks at its ninth annual meeting Sept. 3-5, Boston. The group met jointly with the sixth congress of the International Society of Blood Transfusion.

Dr. Oscar B. Hunter Jr., Washington, D.C., was named president-elect. Dr. Morten Grove-Rasmussen, Boston, was elected vice president and Bernice Hemphill,

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5. Extra duty models and hospital type "Q" stills are equipped with constant bleeder device to continuously deconcentrate impurities thus retarding scale formation.
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More than 200 models including capacities of ½ to 1,000 gallons per hour. Full automatic controls, storage tanks, purity controllers also available.

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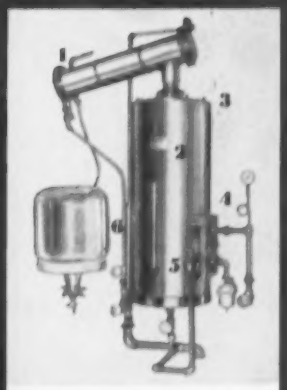

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Barnstead Purity Safeguards produce pyrogen-free water for every hospital use . . . . you find them all in the BARNSTEAD 15

15 GALLONS PER HOUR

San Francisco, was reelected treasurer. Secretary Marjorie Saunders, Dallas, was also reelected.

Mental Health Group Names Two to Head Research Projects

Morris S. Schwartz, Ph.D., and William F. Soskin, Ph.D., have been named to head research projects with the Joint Commission on Mental Illness and Health, Dr. Jack R. Ewalt, commission director, announced last month.

Mr. Schwartz has begun work on a study of what happens to the mentally ill in hospitals—general, private, and public. This is one of four commission groups studying patterns of psychiatric patient care in terms of rehabilitation, supporting agencies of the community, and nonhospital mental health clinics.

Mr. Schwartz, who holds a doctor's degree in sociology from the University of Chicago, was a social science consultant with St. Elizabeth's Hospital, Washington, D.C., prior to joining the commission.

Mr. Soskin has been appointed to direct a study aimed at a systematic assessment of the research effort in mental health. Ways of making this information most readily available to decision-makers in the field are also to be investigated.

Mr. Soskin holds a doctorate in clinical psychology from the University of Michigan. He has been an assistant professor of psychology at the University of Chicago and a research assistant for the American Psychological Association, Washington.

ICS Congress Hears About Future Uses of Anesthesia

A day when a patient will walk into a hospital, be operated on under a general anesthetic, and then leave after the effect of the drug wore off was foreseen by Dr. John S. Lundy, professor of anesthesiology at the Mayo Foundation Graduate School of the University of Minnesota. He spoke before the combined 10th biennial congress of the International College of Surgeons and the 21st annual congress of the United States and Canadian sections, in Chicago last month. The groups also held elections.

Dr. Lundy anticipated that a quickened postoperative recovery from anesthesia would permit hospital nurses to devote more time to other patients, thus easing the nursing shortage.

In another address, Dr. Ross T. McIntire, ICS director and former surgeon general of the Navy, said that still more attention should be directed toward the rehabilitation of the physically-handicapped and the older worker.

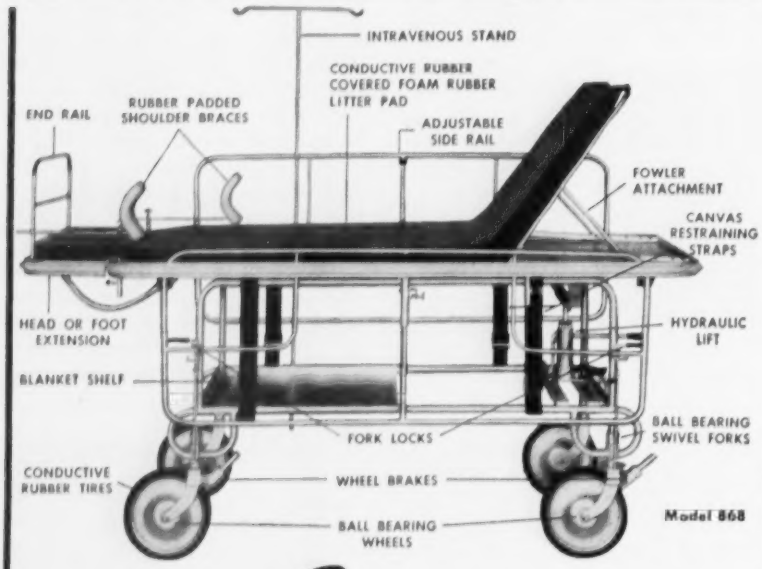
If measures are not taken to aid these groups, Dr. McIntire said, in 20 years "we will have one person retired to every one working."

The college and its sections, besides hearing the addresses, held elections and awarded honors.

Dr. Carlos Gama, professor of neurosurgery in the Faculty of Medicine, University of Sao Paulo, Brazil, was installed as ICS president. He succeeded Dr. Rudolf Nissen, director of the department of surgery, University of Basel, Switzerland.

Dr. Henry W. Meyerding was chosen as president-elect; he will assume the presidency in 1958. Dr. Meyerding is emeritus professor of orthopedic surgery at the Mayo Foundation for Medical Education and Research, Graduate School of the University of Minnesota.

Dr. Curtice Rosser, chairman of the division of proctology of Bay-



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MEASURE OF SERVICE . . . MARK OF INTEGRITY

lor University Hospital, Dallas, Tex., and chairman of proctology in the Southwestern Medical College of the University of Texas, Dallas, was installed as president of the United States section of ICS. Dr. Rosser succeeded Dr. Arnold S. Jackson, head of the Jackson Clinic, Madison, Wis.

Dr. Edward L. Compere was named president-elect of the United States section. Dr. Compere is chairman of the department of orthopedic surgery, Wesley Memorial Hospital, and consultant orthopedic surgeon to Augustana, Henrotin, and Chicago Memorial Hospitals, all Chicago. He is also professor and chairman of the department of bone and joint surgery and supervisor of orthopedic postgraduate training, Northwestern University Medical School. He is to assume the presidency in 1958.

Dr. Nissen and Dr. Felix Mandl, director and surgeon-in-chief of the department of surgery, Franz Josef Spital Hospital, Vienna, Austria, were accorded the college's highest honor, master surgeon. The awards were in recognition of their pioneering work in the field of surgery.

Twenty-one honorary fellowships and an honorary membership were also conferred.

Los Angeles was chosen as the site for the 1958 biennial congress of ICS and the annual congress of the United States and Canadian sections.

Pharmaceutical Group Names Joseph B. Burt as President

Joseph B. Burt, dean of the College of Pharmacy of the University of Nebraska, was named president-elect of the American Pharmaceutical Association through a mail poll of its membership. Mr. Burt is to be installed at the APA convention in New York City, April 28, 1957.

MR. BURT

Also picked were: first vice president-elect, J. Warren Lansdowne, Indianapolis, manufacturing pharmacist, and second vice president-elect, Leroy A. Weidle Sr., St. Louis, pharmacist.

Members-elect (for three-year terms) of the Association's council are: Roy A. Bowers, Newark, N. J., pharmaceutical educator and dean; Grover C. Bowles, Memphis, Tenn., hospital pharmacist, and John B. Heinz, Salt Lake City, pharmacist.

President John A. MacCartney will continue in office, as will the two vice presidents, until the convention.

Mexican Hospital Association Names Officers for Coming Year

The Mexican Hospital Association has named new officers for the coming year. Elected were: president, Dr. Carlos Zamarripa Torres; vice presidents, Dr. Manuel Barquin Calderon and Dr. Martin Luis Guzman; secretary, Enrique Garcia Esquivel, and treasurer, Julio Olavarria.

Canadian Nurses Approve Study Of Nursing School Accreditation

Delegates to the 28th biennial convention of the Canadian Nurses' Association last month, approved a two-year study looking toward the establishment of an accreditation program for nursing schools. Approximately 20 Canadian nursing schools are to be included in the study by CNA's committee on nursing education.

Mildred Schwier, R.N., director of the diploma and associate de-

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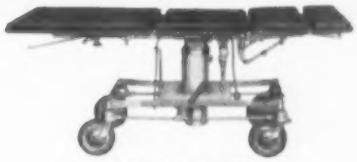
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#25 AR

#25 HR

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#25 GC

#15

#17

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Combination ARM, LEG AND HIP TANK, Model HM 601 . . . Stationary, stainless steel unit for hydromassage and subaqua therapy. Water mixing valve is thermostatically controlled.

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gree programs for the National League for Nursing, and Margaret G. Arnstein, R.N., chief of the division of nursing resources, Public Health Service, were among the convention speakers.

Hospital in Saudi Arabia Accredited by U.S. Commission

Arabian American Oil Company's health center in Dhahran, Saudi Arabia, has been fully accredited by the U.S. Joint Commission on Accreditation of Hospitals, Aramco and the Commission have announced.

The Dhahran installation is one of approximately a half dozen outside Canada and the United States and its possessions which have been accredited by the Commission.

The center, built for $3.5 million, has a clinic, a 340-bed hospital, and a research section. It also maintains a nursing school which presently has 82 students.

An additional 67-bed medical wing and a 40-bed isolation ward are now under construction. The complete center, the oil company said, will represent a $6 million investment.

Two Mississippi Hospitals Close

Scott County Hospital, Morton, Miss., and Brandon (Miss.) Hospital have closed.

The hospital in Morton closed in mid-August after 19 years of operation. Mrs. O. J. Burnham, owner, said that closing of the hospital was determined by increased operating expenses and scarcity of help. It was not known whether local citizens will attempt to reopen the institution.

The Brandon Hospital is a 50-bed unit built 26 years ago. No plans had been revealed for reopening the facility which had been up for sale.

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WASHINGTON REPORT

(Continued from page 109)

Army areas. For the Rocky Mountain, West Coast and eastern seaboard states, this responsibility would be given to Blue Cross.

Small Business Administration

After several months delay, occasioned by restudy and subsequent alteration of its original plans, the Small Business Administration is making federal small loans available to proprietary hospitals, nursing homes, and medical laboratories.

As finally adopted, eligibility criteria exclude hospitals with more than 50 beds. The same ceiling is applicable to privately owned nursing and convalescent homes. The latter can qualify if they serve "persons who are not acutely ill and not in need of hospital care, but who may require nursing care and related medical services."

All medical and dental laboratories shall be considered to be small businesses, and therefore eligible for government loan aid, unless they are operated in connection with proprietary hospitals having more than 50 beds.

Loan money may be used for construction of new facilities, improvement or expansion of existing plants, or for working capital.

Qualifying considerations listed by SBA are:

1. The applicant must show that the needed financing is not otherwise available on reasonable terms from another credit source.
2. The applicant must show that the loan can be repaid out of earnings.
3. The owners and operators of

Berea College Hospital Test of 3 most-used methods prove that the

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BRACELET SYSTEM
is the

Fastest, Easiest Method For Immediate Patient Identification!

For babies
Presco Bracelets meet all requirements recommended by the A.H.A. Pink and blue to identify sex.

For Adults

For use in surgical cases, blood transfusions, the emergency room and in multiple-bed rooms—a never failing "double check" for complete accuracy—a protective procedure patients are glad to pay for.

Safe . . . Can't slip off. So sure, so trustworthy that it must be cut off.

Fast . . . Easy pressure of fingers snap-locks bracelet onto patient's wrist. No awkward tools or gadgets needed.

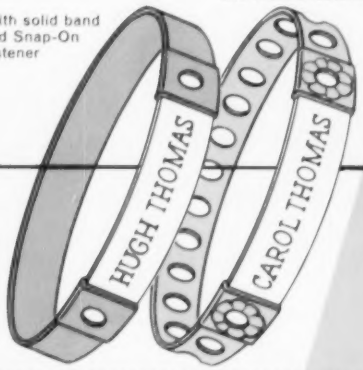
Comfortable . . . Soft, pliable, non-toxic plastic conforms to wrist. Won't impair circulation.

Attractive . . . Beautiful pink, blue and white plastic. Parents invariably want to buy bracelets as keepsakes—so they pay for themselves.

*Only **3** Simple Steps!*

1. *Write desired information on pre-cut card.*
2. *Slide into transparent holder.*
3. *Slight pressure of nurse's thumb and finger snap-locks bracelet onto patient's wrist. It takes only seconds!*

Available in two types...



Presco Baby Kit:
144 complete bracelets (72 pink and 72 blue) **$59.75**

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144 complete bracelets (All pink, all blue, or all white) **$59.75**

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144 baby or adult style bracelets **$43.20**

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3. Folds to 3-inch thickness for compact storage.
4. Handsome vinyl panels present a fresh, modern appearance. Snap-out rods mean easy removal for cleaning. Aluminum is anodized for lifetime satin finish. Also available with handsome gold finish ($5 extra).

3-Section Regular Model $34.50
3-Section Deluxe Model $44.50
Prices effective November 1st

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Help Reduce Cross-Infection —Ideal for sick babies and healthy babies —The solution to overcrowded nurseries

Your Assurance That You'll Never Be "Short" of Bassinets.

PRESCO *Disposable Bassinets are made of strong, rigid, water-resisting Flute-wood stock. Lightweight yet sturdy, one-piece construction . . . decorated in either pink or blue designs.*

Delivered flat and can be folded and assembled in one minute.

Please specify color or colors desired.

	East of Rockies	West of Rockies
In lots of 18 to 72	$1.75 per bassinet	$1.83 per bassinet
In lots of 90 to 216	$1.55 per bassinet	$1.63 per bassinet
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Packed 18 pink or 18 blue to a carton (wt. 30 lbs. per carton.)

- No Scrub-Up — No Disinfecting
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- Fits Most Bassinet Stands
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an applicant facility must be experienced in their field, must be competent, and must have sufficient professional training to operate the facility in accordance with required or accepted standards.

4. When licensing is required by a state, county or local agency, the facility must have a license in good standing or the licensing agency must indicate, in writing, that a license will be issued when the purpose for which the loan proceeds have been used are completed.

5. An applicant will not be deemed to meet the necessary credit requirements nor to have demonstrated adequate ability to repay the loan, if its facility, after application of the proceeds of the loan applied for, does not meet the minimum standards generally accepted for such facility.

SBA makes no charge for handling a loan application or for counseling an applicant on his financial problems.

PHS Medical Officers

Applications for a competitive examination for appointment to the regular corps of PHS are being accepted until Oct. 13. The examination will be held in various places throughout the country Nov. 27-30.

Appointments provide opportunities in clinical medicine, research, and public health and are made in the ranks of assistant and senior assistant. Entrance pay for both grades with dependents is $7,498 per year, plus other benefits. Active duty as PHS officer fulfills Selective Service obligations.

Application forms may be obtained from the Chief, Division of Personnel, PHS, HEW, Washington, D.C.

Health Amendments Act

The program to increase the number of professional nurses with advanced training, practical nurses and public health personnel, authorized under the Health Amendments Act of 1956, is moving forward, HEW reports. Many nurse students are already enrolled for the fall school term.

Title I of the act received a $1 million congressional appropriation for 250 traineeships for graduate training of professional public health personnel. One hundred nurses will receive one year traineeships in 33 schools participating in the program. Of the remaining 150 traineeships for other public health personnel, some will be available through schools, but the majority will go directly to students. So far, about 55 direct applications have been approved.

Under Title II, which provides for advanced professional nurse training, 40 of the 55 participating institutions have applied for grants. These 40 institutions will train 434 students, their maximum under an allotment formula. They reported over 150 more applications than they could fill. About 550 traineeships will be available under the $2 million congressional appropriation.

Extension and improvement of practical nurse training, provided for in Title III, will come under Vera P. Hansel, R.N., newly appointed to the position of chief, Practical Nurse Education, Office of Education.

This program differs from the other two in that no stipends are provided; grants are made to states. Upon the approval of a state

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plan, the federal government, using an allotment formula, will pay up to 75 per cent of the cost of carrying out the plan. This proportion will be for the first two years; during the remaining three years it will drop to 50 per cent.

National Library of Medicine

The Armed Forces Medical Library was to be converted to the National Library of Medicine Oct. 1. Lt. Col. Frank B. Rogers, director of the present library, will continue in that capacity indefinitely. Public Law 941, passed by the 84th Congress, authorizes the reconstitution and also provides for a new building to replace the present obsolete structure. Site of the new structure will be determined by a newly created board of regents. Names of the board are expected to be announced shortly.

Civil Defense Hospitals

Fifty civil defense emergency hospitals have been offered on a loan basis to state and local civil defense offices for demonstration, exhibit, or training purposes in their areas. Hospitals interested in borrowing one of the emergency hospitals should contact their regional Federal Civil Defense Administration offices.

Thirty-seven hospitals have been loaned. They are located in: Chandler, Ariz.; San Francisco; Greeley, Colo.; Torrington, Conn.; Wilmington, Del.; Washington, D.C.; Atlanta; Boise, Idaho; Evanston, Ill.; Indianapolis; Cedar Rapids, Iowa; Topeka, Kans.; Sykesville, Md.; Detroit; Moose Lake, Minn.; Oak Terrace, Minn.; Rolla, Mo.; Warm Springs, Mont.; Boystown, Nebr.; Omaha, Nebr.; Reno, Nev.; Sommerville, N. J.; Chillicothe, Ohio; Salem, Ore.; Altoona, Pa.; Butler, Pa.; Reading, Pa.; Providence, R. I.; Memphis, Tenn.; Baylor University, Tex.; Houston, Tex.; Salt Lake City, Utah; Barrie, Vt.; Seattle; Charleston, W. Va.; Honolulu, Hawaii, and Arnprior, Ont., Can.

Care of Indians

The federal government operates 56 PHS Indian hospitals, having 3,815 beds, and has 160 hospitals (with 1,800 beds) under contract to care for approximately 315,000 Indians living on 250 reservations in 24 states, and approximately 35,000 natives in the territory of Alaska, according to HEW figures released recently.

Statistics also show Indians have available approximately 50 community hospitals providing emergency care, 14 infirmaries at off-reservation Indian boarding schools, 20 health centers (curative and preventive services), approximately 100 other field health stations, and 2 practical nurse training schools.

Estimated 1956 PHS Indian hospital admissions were set at 46,000; contract hospital admissions, 8,500. Estimated 1956 daily census in PHS Indian hospitals was set at 2,700 and in contract hospitals at 1,500. Outpatient treatments in 1956 in PHS Indian hospitals were estimated at 550,000, and at health centers at 180,000.

HEW said $34.8 million was appropriated for Indian Health activities in 1956 and $38.8 million for 1957. The department also said $5 million had been appropriated for construction of Indian health facilities in 1956, and $8.8 million for 1957.

Vocational Rehabilitation

As part of its nationwide training program designed to help overcome the shortage of professional workers qualified to help in vocational rehabilitation, the federal government made more than $2 million available in the year ended June 30.

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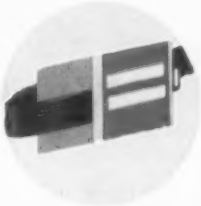

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Funds went to educational institutions and individuals under terms of the Vocational Rehabilitation Act of 1954. Educational institutions in 31 states received a total of 154 teaching grants which paid part of the cost of establishing or expanding training courses for rehabilitation workers.

More than 2,000 students received training in rehabilitation at a cost of more than $1 million to the federal government for the traineeships.

Eighty-four per cent of the training grants went to support basic professional training; the remainder for short-term refresher courses. Fields covered: medicine, rehabilitation counseling, social work, nursing, occupational therapy, physical therapy and work with the blind.

Institutions participating in the medical and nursing part of the program are: Yale University, University of California, Georgia Warm Springs Foundation, Illinois Institute of Physical Medicine and Rehabilitation, Loyola University, University of Kansas, Boston University, Harvard Medical School, Massachusetts General Hospital, Tufts University, University of Minnesota, Columbia University, Albany Hospital, Montefiore Hospital, New York University, Bellevue Medical Center, New York Medical College, Yeshiva University, Institute of Physical Medicine and Rehabilitation, University Hospital of Cleveland, Pennsylvania State University, Hospitals of the University of Pennsylvania, University of Pennsylvania, Vanderbilt University, Baylor University Hospital, University of Utah, University of Virginia Hospital, Medical College of Virginia, University of Washington, Marquette University, and George Washington University.

Research Fellowships

The National Research Council's Division of Medical Sciences has announced it will accept applications until Dec. 1 for postdoctoral research fellowships which are administered by its fellowship board. Awards will be for 1957-58. Donors of these fellowships are the Rockefeller, Donner, John and Mary R. Markle, and James Picker Foundations.

PHS Grant

Michigan State University has been given $125,000 by PHS to conduct a five-year study of hospital-community relationships.

Among the subjects to be considered: sociological aspects of hospital financing and building programs, the role of auxiliary organizations, volunteer workers, nurses, doctors, administrators, and others responsible for the relationship that the hospital and community have toward each other.

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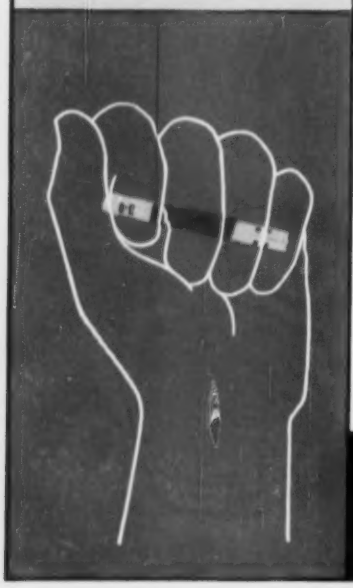

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(Continued from page 53)

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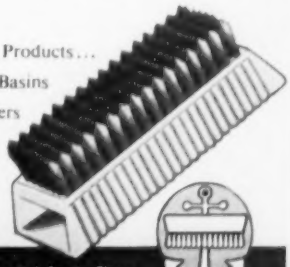

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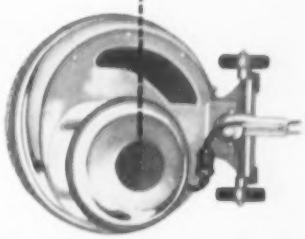

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The hospital-specialist controversy: where does the solution lie?

(Continued from page 50)

which is an absolute necessity if he is faithfully to fulfill his obligation to his patient. Whenever anyone contracts to provide people with what is referred to as "needed medical care," the physician loses some part of his freedom to protect the interests of his patient, and becomes a technician, employed to provide such "services" as may be deemed necessary.

In the case of the hospital, the administrator is likely to say that this does not apply, because the physician is given complete freedom to treat the patient in accordance with his best scientific and professional judgment. This freedom is not enough, however, for two reasons. First, it must always be true that "he who holds the purse-strings calls the tune" at least to the extent of putting *some* limit on what may be done. Second, the function of a physician is *not* to treat people in accordance with his best scientific judgment.

The function and objective of the physician is to help his patient achieve such health and such recovery of happiness and function as are possible for him. The tools of medical science are simply tools—no more and no less. The doctor may not, and his science cannot, dictate what the treatment shall be. He should refuse to be party to treatment which he believes unsuitable, but beyond that, he can only recommend. The patient retains final right to accept or reject his advice. The idea that treatment can be determined scientifically is one of the most popular modern ideas, but is completely false.

The practice of medicine is an art—the art of using science, experience, and even the inspired

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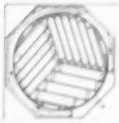

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guess, to help people meet their individual health problems. It defies mechanization, standardization, and mass-production. The idea that there is something called medical care, more or less analogous to nursing care, which can be "supplied" to those who need it, is wholly and disastrously false. Yet that is the basic idea behind the belief that hospitals can hire doctors to provide people with "medical care."

The assertion you hear so often, that "the hospital should assume its rightful place as dispenser of medical care to the community," if fulfilled, would prove the worst nightmare this country has ever experienced.

Where does the radiologist fit into this picture? In the field of therapy, his function is the same as that of any other physician. In the field of what is known as diagnostic x-ray, even though he rarely sees the patient, his function is the same as that of any other medical consultant. That is why he is expected to be a licensed physician.

The function of the radiologist is not to perform examinations of various organs and report on their condition to the personal physician. It is to obtain for the referring physician such information as x-ray can obtain, and help him interpret it in terms of the needs of the patient. Every x-ray examination is properly a medical consultation.

Unless the factor of consultation exists, the radiologist fails his function as a physician, and care of the patient suffers. It is generally agreed that radiology, properly practiced, *is* practicing medicine, and that when the radiologist is employed by a corporation which sells his services, they are "commercialized, to the public detriment" just as in the case of any other physician.

According to the Iowa decision, however, a hospital not only may not employ a radiologist or pathologist and sell his services—it may not even operate an x-ray or pathology laboratory. It was "the conclusion of the court that under the facts established . . . and the law as the court understands it, that the work done by the pathologist, radiologist, and the technicians working in the pathology and x-ray laboratories, constitutes the practice of medicine."

The reason for this requires a little further analysis, but the court was right.

Nurses and pharmacists are trained to execute certain orders given by the doctor in his treatment of the patient, and are licensed to assume direct responsibility to the patient for carrying them out skillfully and properly. The question naturally arises of why the same thing cannot be done in the case of technicians. The reason is not hard to understand when the facts of the case are considered.

When the nurse or pharmacist carries out orders of the doctor, the doctor has already decided what he wants done for the patient, and can give instructions to a trained person. The work of the technician carries responsibility of a vastly different nature. When it is done the physician does not know what the patient needs, and the work is part of the process of finding out. Any failure of the nurse results only in wrong results of treatment, but a failure of the technician results in wrong objectives of treatment—a much more far-reaching error.

Moreover, x-ray examination is not a matter of carrying out fixed procedures, which a person can be trained to carry out without supervision. It is a matter of adapting x-ray methods to obtaining the particular information needed for the particular problem. This means that the technician must function at all times under the direct supervision and complete control of the radiologist, to the extent that the latter can be personally responsible for the reliability and suitability of everything that is done, and so completely aware of what was done, and how, that there can be no question in his mind as to its significance.

There are many ways of giving a hypo, or compounding a prescription, and which is used makes no great difference. The interpretation of an x-ray or laboratory examination may go far afield if the interpreter does not know ex-

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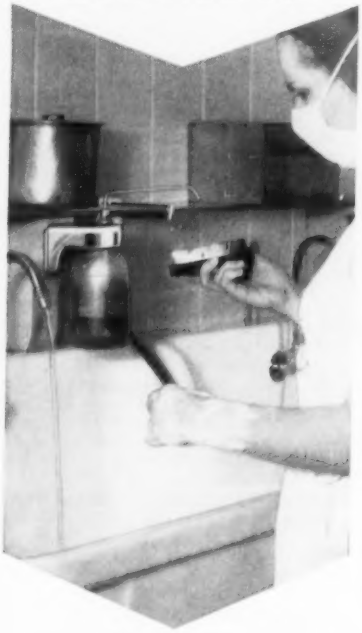

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actly how it was performed. Consequently, the technician should be, whenever possible, the employee of the person who interprets the results; and *must* be as completely under his control as if he were an employee—or the reliability of the interpretation suffers.

Nevertheless, it is necessary that pathology and x-ray laboratories exist in hospitals and that they be there under conditions which protect the rights of the hospital as well as those of patients and their physicians. Just how this can be done, I am not sure. I *am* sure that it can and must be done. I am also sure that the same methods will not be found suitable in an isolated rural community, a suburban hospital, and a large urban institution; but that in every case the particular solution must conform to the same fundamental principles.

I suspect that in many cases the hardest problems arise from the natural monopoly which necessity creates for the hospital radiologist or pathologist. This is a tough one, but the bad effects can certainly be minimized.

And we must not forget that the monopoly is not primarily because of the desire of the physician. The hospital certainly doesn't want a dozen x-ray departments; and, quite aside from the almost impossible problem of scheduling time in the department, in general it does not want a dozen radiologists, each with his own technicians, messing around a department in which the hospital owns the equipment. Or do you?

Whatever the practical difficulties to be overcome, I believe they can be met successfully if hospitals recognize that there is something more to the practice of medicine than "providing needed medical care" and if they will recognize that physicians are not just being arbitrary and arrogant when they insist that a hospital actually cannot—and should not pretend to—practice medicine. If then, they will get together with the doctors and discuss, in friendly spirit and good faith what needs to be done, they can work out together a solution that protects the rights of all; and that will preserve *professional* medicine for ourselves and for our children of the next generation. ■

Why Faucets Leak

Faucet washers, when fastened with TOO LONG or SHORT screws — as in "9 out of 10" replacements by best mechanics — quickly work loose, destroy themselves!

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When installed with NEW Pat'd. "Sexauer" EASY-TITE faucet washers, this combination outlasts past faucet repairs "6 to 1"!

EASY-TITES are made of super-tough, pliable duPont compound (neither rubber nor fibre) to withstand super-hot water and make tight even on worn, corroded seats. They are further *reinforced* with a vulcanized layer of Fiberglas to resist distortion and splitting from shut-off squeeze.

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Company or Institution _____

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WORLD'S LEADING SPECIALISTS IN PLUMBING AND HEATING REPAIR PARTS

Hospital association meetings

(Continued from page 6)

South Carolina Hospital Association—January 18, Columbia (Wade Hampton Hotel)
South Dakota Hospital Association—October 8-9; Rapid City (Sheraton-Johnson Hotel)
Vermont Hospital Association—October 17-18; Pico Peak, Rutland (Long Trail Lodge)
Virginia Hospital Association—November 16-17; Roanoke (Hotel Roanoke)
Washington Hospital Association—October 10-11; Yakima (Chinook Hotel)
West Virginia Hospital Association—October 11-13; Parkersburg (Hotel Chancellor)
Wisconsin Hospital Association—March 17; Milwaukee (Hotel Schroeder)

AHA INSTITUTES

(THROUGH MARCH 1957)

Evening & Night Nursing Service Institute—October 1-4; Dallas (Adolphus Hotel)
Medical Record Library Personnel Institute—October 15-19; Richmond, Va. (Hotel Jefferson)
Administrators' Secretaries Institute—October 22-25; Chicago (Edgewater Beach Hotel)
Operating Problems for Small Hospitals Institute—October 25-26; Burlington, Vermont (Vermont Hotel)
X-Ray Technicians Institute—October 30-November 1; Chicago (Shoreland Hotel)
Hospital Auxiliary Leadership Institute—November 1-2; Cleveland (Carter Hotel)
Nursing Service Administration Institute—November 5-9; Cincinnati (Sheraton-Gibson Hotel)
Operating Problems for Small Hospitals Institute—November 1-2; Winnipeg (Royal Alexandra Hotel)
Physical Therapy Institute—November 5-9; San Francisco (Sir Francis Drake Hotel)
Workshop on Disaster Experience—November 8-10; Chicago (Lake Shore Club)
Operating Room Administration Institute—November 11-15; Fresno (Fresno Hacienda)
Dietary Department Administration Institute—November 12-16; Denver (Cosmopolitan Hotel)
Operating Problems for Small Hospitals Institute—November 14-15; Phoenix (Westward Ho Hotel)
Supervisory Training Workshop—November 26-30; Montreal (Sheraton-Mount Royal Hotel)
Hospital Safety Seminar—November 26-30; Chicago (Congress Hotel)
Maintaining Standards of Patient Care in Hospital Systems Institute—November 28-30; Hershey, Pa. (Hershey Hotel)
Obstetrical Nursing Service Administration Institute—December 3-6; Toronto (King Edward Hotel)
Methods Improvement Institute—December 3-7; Highland Park, Illinois (Moraine-on-the-Lake Hotel)
Nursing Service Administration Institute—January 7-11; Birmingham (Dinkler-Tutwiler Hotel)
Hospital Dietary Administration Institute—January 21-25; Minneapolis (Leamington Hotel)
Hospital Auxiliary Leadership Institute—February 5-6; Dallas (Baker Hotel)
Central Service Administration Institute—February 11-14; Atlanta (Henry Grady Hotel)
Hospital Dietary Administration Institute—February 18-22; Columbus (Deshler-Hilton Hotel)
Nursing Service Supervision Institute—February 25-28; Chicago (Shoreland Hotel)
Hospital Planning Institute—February 25-March 1; Chicago (Edgewater Beach Hotel)
Hospital Dietary Administration Institute—March 4-8; Winnipeg (Royal Alexandra Hotel)
Organization, Plant Management Functions Institute—March 4-8; New York (Park Sheraton Hotel)
Evening & Night Nursing Service Supervisors Institute—March 11-14; Roanoke (Hotel Roanoke)
Medical Record Library Personnel Institute—March 11-15; Chicago (Shoreland Hotel)
Hospital Dentistry Institute—March 11-15; Washington (Sheraton Plaza Hotel)
Staffing (Nursing) Institute—March 25-27; Chicago (Shoreland Hotel)
Hospital Engineering Institute—March 25-29; Denver (Olin Hotel)

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Solution or stopgap?

(Continued from page 57)

at the best possible solution. A project of adequate scope would need the inspiration and guidance of some coordinating agency, in order to insure uniformly gathered data which form a necessary base for sound conclusions. The completion of such a cooperative endeavor would constitute a step forward in the development of the science of hospital records management. ■

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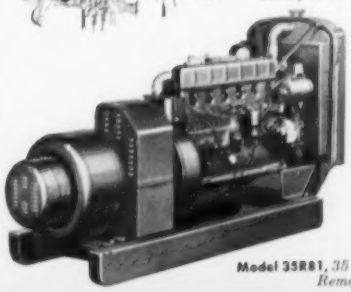

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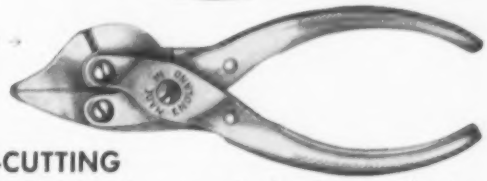

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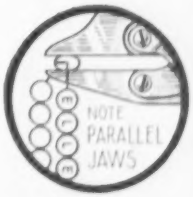

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JOHN H. HAYES

Many hospitals publish booklets for patients, telling them what to bring, what will be done for them, etc.

One patient in a hospital carefully read the booklet given him; and then told the administrator that the hospital had omitted mentioning one item which he considered important: The booklet did not tell him how he was going to be able to pay his bill.

* * *

Why is it that most of the times when a man is quoted they quote the things he is sorry he ever said or wrote?

* * *

In my opinion tipping is cheating. It usually takes away from the giver more than he should pay; it reduces the dignity of the receiver; and—very often—income tax paid to the government. Tipping does not belong in hospitals, where everyone is supposed to get the utmost service, no matter what he can afford.

I'm not cheap. I just want to know what something I buy is going to cost, whether it be goods or services. I don't want more than the other fellow gets.

Tipping is like what Mark Twain said about the weather: Everybody kicks about it; but nobody ever does anything about it.

* * *

Because there are so many patients, those who operate large hospitals often forget that the average sick person feels honored and more at home if he is visited by the administrator or the director of nursing.

He who gets to know the head of the house is no longer a stranger.

* * *

The fact that "the quality of mercy is not strained" should be most evident in hospital workers.

Those who find it an effort to be merciful are in the wrong calling.

* * *

The best remedy for insomnia is not a pill. It is the conviction that you have done a good day's work.

* * *

When people ask me why this column is always in the back pages I tell them that it is because the front part of this Journal is for educational articles only.

* * *

I have just built and moved into a new home which my wife and I had planned. We learned a lot; but what astounded us most was the independence of workingmen today. They seem to decide each day whether they will work or take the family to the seashore.

I told some of them about hospital operation and asked how they would like it if hospital workers also followed their practices.

You will not be astonished to learn that I did not impress them.

* * *

Many of the best decisions are arrived at by men while they are taking long walks. We do very little walking these days; and that may account for many of our unwise decisions.

Yes . . .

There's MORE Than One Good Reason for USING OUR RECORD BOOKS

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Chicago 11, Illinois

ADMINISTRATORS: (a) Med. dir., new 400-bed hosp. for chronic & infirm patients; pref. one trained geriatrics, physical or internal med. (b) Med. supt. small hosp. for mentally retarted children; staff includes bus. mgr; $12,000; attrac. home; W. (c) Ass't med. dir; hosp. group; med. center. MW. (d) Gen. com. hosp; 325 beds, coll. town, S. (e) Ass't supt, mun. hosp, 2000 beds; would be second-in-command; med. center, E. (f) Ass't, 400-bed gen. hosp. affil. med. school, $6000-$8000. (g) Ass't, 300-bed gen. hosp; degree, accounting background required; Texas. (h) Woman; 20-bed modern hosp; built in 1952; prosperous farm area; $5400, mtce. H10-1

ANESTHETISTS: (a) Outside U.S.A., Alaska, Hawaii, Tahiti; to $7500. (b) Male Nurse Anesthetist; group of 4-2 M.D.'s 25 hour week; $6000; So. Calif. (c) Progressive, new, busy clinic, wealthy mining ranch area; 80° mean temperature; SW; $6000. (d) Two; 120 bed hosp. exclusive Chicago suburb on Lake Michigan; $6000. H10-2

DIETITIANS: (a) Dietary consultant to 4 hosps. within 200 mile radius; ideal year-round climate; SW; good salary, car furnished, travel expenses. (b) Dietitian for luxury hotel, Florida; December—April; also Maine resort May—Oct. H10-3

DIRECTORS OF NURSING: (a) Leading 400 bed hosp, univ. affil; exceptional rating; no school; excel. future oppor; paid univ. tuition; key city, E; $7500. (b) Dir. of Nurses; 350 bed well estab. hosp; remodeling, adding 100 beds; 150 students; reorg. ability desirable; coll. town of 150,000; MW; top salary. (c) Dir. of Nurses; 200 bed gen. hosp; small school; near lge indus. city; Penn; $6400-$8200. H10-4

FACULTY POSTS: (a) Dir. Nursing Educ; plan, org. affil. ped. hosp & coll. school; unlimited oppor; $6000; adjacent campus leading men's univ. (b) Univ. Pre-Nursing Advisor; recruit students throughout beautiful NW state; teach on campus; faculty status; $5000; travel. (c) Science Instructor 450 bed med. coll. hosp; teach anatomy, physiology, pharmaceutics; Greater Manhattan; top salary. (d) Psychology Instructor, newly organ. coll. school; lake campus; metro. area; progressive MW city; $5600. H10-5

MEDICAL RECORD LIBRARIANS: (a) Chief, lge gen. hosp; reorg. prog; cooperative admin; Fla; $5000. (b) Chief; reorg. dept. 15 busy out-patient; plans to expand to 750; near NYC. H10-6

SUPERVISORS: (a) Night; 35 bed hosp; excel. oppor, utilize admin. ability; near lge city; good working conditions, salary, NW. (b) Ped; 300 bed hosp; best personnel policies; new, modern facil; $5000, Ohio. (c) OB; 250 bed hosp. near Lake Michigan; good educ. possibilities; metro. area; univ. center; $5000; MW. (d) Supervisor, home for 80 retired business women; beaut. grounds, wealthy suburb; attrac. living accom; act as ass't admin. (e) Orthopedic and Ass't; brand new air-conditioned Orth. suite; latest equip, conveniences; near Wash. D.C. H10-7

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ADMINISTRATORS: (a) Med dir, 135 bed hosp for mentally retarded; psy exp not nec; $12,000, full mtce, plus beautiful 7 rm furn hom not on hosp grnds; SW. (b) Gen hosp 350 bds; very desirable univ twn 85,000; yr round warm climate. (c) Hosp & home; 25 bds; expansion prog; shld be Jewish; good sal, 3 bedrm home, full family mtce; lge city. (d) Complete chge all non-med problems; report dir to Med Adm; 350 bd gen hosp; West Coast. (e) Fairly new gen'l hosp, JCAH, 100 beds; county seat; MidS. (f) JCAH, gen county hosp, 100 bds; California. (g) New genl hosp, 100 beds, under construction; delightful twn; South. (h) Gen corp 50 bd hosp; to $6,000; Ozarks, Mo. (i) Ass't; vol genl hosp 225 bds, tchg prog; about $8,000; lge city on Lake Mich. (j) Ass't gen vol hosp 500 bds; univ city 250,000; MW. (k) Ass't; 800 bed tchg hosp; $7500; lge city; univ med cntr; MidE.

ADMIN. EXEC. PERSONNEL: (a) Accountant; to serve as consultant to lge hosp grp; some tch'g; travel; $7-9,000; univ center MW. (b) Bus Mgr; 100 bd gen vol hosp expand'g to 175; accnt'g, credit & coll backgrnd; univ city; E. (c) Clinic Mgr; cl est'52 rapidly expand'g; staffed by faculty men; occupying separate wing, univ hosp; to $10,000; So. (d) Comptroller, Purchas'g Dir, and Dir, Personnel & Publ Rel; 3 separate posts; gen 250 bed hosp increas'g to 450; town 100,000 nr univ cntr; MidW.

ADMINISTRATORS-WOMEN: (a) R.N.; 40-bd gen hosp to be compl early '57; lovely resort twn; MW. (b) R.N. or non-med; gen hosp 60 bds, to be built; W. (c) R.N. or non-med; 100-bd gen hosp, 4 yrs old; SE.

ANESTHETISTS: (a) Vol gen hosp 150 bds; $450, room; W. (b) To $500; gen hosp 200 bds; coll twn 25,000; N. Engl. (c) Newly open'd 25-bd gen hosp; $500; prog Fla resort.

DIETITIANS: (a) Chief; well staff'd, equip'd dept; vol gen hosp 65 bds; lovely N.Engl. resort area. (b) Full resp, build & est dept, hosp, 150 bds; 250-bd potential; Calif.

DIRECTOR of NURSES: (a) Nurs serv only; 75-bd gen hosp; newly created post; to $6000; resid twn 10,000 nr lge univ city; Pac NW. (b) Nurs serv & ed; 60 students, 150-bd gen hosp; coll city 25,000; MW.

EDUCATIONAL DIRECTORS: (a) Ass't; 50 students; apprvd school; 200-bd gen hosp; impor univ med ctr; E. (b) Coll affil school, 65 students; gen hosp 150 bds; to $5400; resort area SW.

EXECUTIVE HOUSEKEEPERS: (a) Supv staff of 25 in dept, 200-bd gen hosp; nr NYC. (b) Newly compl vol gen hosp 125 bds, excep deluxe facil & equip; wealthy resid suburb Chgo.

DIRECTOR OF NURSES; also NURSING ARTS INSTRUCTOR: 120 bed general hospital, city of 17,000, southern Minnesota. Adequate academic preparation and successful experience required. Contact Administrator, Neave Hospital, Albert Lea, Minnesota.

INSTRUCTOR FOR NURSES' AIDES: General Hospital treating men, women and children. 128 adult and pediatric beds plus 24 bassinets. 40-hour week. Salary open. Apply Director, Woman's Hospital, 1940 East 101 St. Cleveland 6, Ohio.

MEDICAL TECHNOLOGISTS—Opportunities now in modern well equipped general laboratory of 367 bed hospital. Liberal personnel policies including three weeks vacation, two weeks paid sick leave, eight paid holidays and no night or week-end work. Technologists are supervised by two certified pathologists. Salary commensurate with training and experience. Apply —Director of Laboratories, Waterbury Hospital, 64 Robbins Street, Waterbury, Connecticut.

MEDICAL RECORD LIBRARIANS: Basis knowledge modern medical records, methods and techniques. Must be registered. New Hospitals in Ky., Virginia, and West Virginia. Good personnel policies, including forty hour work week, four weeks paid vacation, non-contributory retirement plan. Please send applications to Mr. Philip J. Olin, Miners Memorial Hosp. Ass'n. 1427 "I" Street, N.W., Washington 5, D.C.

LIBRARIAN: Medical record; to head dept. in modern, fully approved, midwest hospital. Liberal employee benefits, 40-hour week. Salary dependent on experience and ability. Apply Asst. Administrator, Trinity Lutheran Hospital, Kansas City, Missouri.

ANESTHETIST wanted for 200 bed hospital; good working conditions; 40 hour week; 4 weeks paid vacation; paid sick leave; extra paid for calls; salary open; city of 27,000; apply to Trinity Hospital, Minot, North Dakota.

LIBRARIAN, MEDICAL RECORD—Registered. To assume charge of record room. 135 bed general hospital, 40 hours—salary open. Contact Miss G. A. Cooper, Woman's Hospital, Cleveland, Ohio.

REGISTERED NURSE: Interested in teaching Practical Nursing—opportunities to develop own program. School not approved at present. Desire individual capable of developing program which will meet state approval. Small town located in South East Pennsylvania. Address Box G-74, HOSPITALS.

GRADUATE NURSES—general duty and operating room. Hospital located on university campus. Salary $300.00 per month plus departmental and shift premiums. Apply Director of Nursing, Palo Alto Hospital, Palo Alto, Calif.

OPERATING ROOM NURSES (Male and Female) — Immediate appointments for staff and head nurses in medical center. All types of special surgery. 30 days vacation, 8 paid holidays. Staff nurses—$320 to $335 per month, Head Nurses $335 to $375. Evening duty differential $40. Night duty $30. Write to Associate Director, Nursing Service, Michael Reese Hospital, Medical Center, Chicago 16, Illinois.

DIETITIAN: Registered, qualified to be head of department, supervising menus, special diets, personnel management and has had some institutional experience. Position is in a 200 bed hospital amid pleasant surroundings located in a midwestern Michigan city. Attractive living quarters provided if preferred. 40 hour week, 3 weeks vacation, Social Security, sick leave and holidays with pay. Salary open, commensurate with ability and experience. Address applications in writing only to Sunshine Hospital, 700 Fuller Ave., N.E., Grand Rapids, Michigan.

GENERAL LAB. TECHNICIAN, male or female, two positions open—ultra-modern lab and hospital—delightful college town near Denver and Estes Park. Salary $300 and extra for call. Full-time pathologist and school for lab. technicians. This is an unusual opportunity. Apply H. H. Hill, Administrator, Weld County General Hospital, Greeley, Colorado.

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THE MEDICAL BUREAU

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Chicago 11, Illinois

ADMINISTRATOR: Med; 4 yrs, ass't dir., 500-bed univ. hosp; eight years, adm., 400-bed tch'g hosp; FACHA.

ADMINISTRATOR: R.N., B.S., Nursing; M.P.H. (Hosp. Adm.); 3 yrs, ass't adm, 400-bed gen. hosp.

ADMINISTRATOR: M.P.H., Yale; four years, ass't adm, 400-bed hosp.

ANESTHESIOLOGIST: Diplomate, 8 yrs, priv. pract., dir. dept, 200-bed hosp.

COMPTROLLER: CPA; 5 yrs exp., public accounting; since '50, comptroller, 400-bed hosp.

PATHOLOGIST: M.C. (Path); Diplomate (Path. Anatomy, Clin. Path); 8 yrs. dir. path., 250-bed hosp; recently completed military service.

PERSONNEL DIRECTOR: Professional nurse; A.B. (Sociology); received M.P.S. in June.

PURCHASING DIRECTOR: B.S. state univ; 11 yrs. purchasing dir., lge tch'g hosp.

RADIOLOGIST: Three-year fellowship, univ. center; several years' successful priv. practice; Diplomate (Diag. & Ther. X-ray & Radium Therapy); well trained isotopes.

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WOODWARD

Medical Personnel Bureau

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3rd floor • 185 N. WABASH AVE.

CHICAGO • 1

• ANN WOODWARD • Director

ADMINISTRATOR: B.A., M.H.A.; 3 years, asst admin. 800 bed university hospital; 4 yrs director, 150 bed hosp; outstand'g references; Member ACHA.

ADMINISTRATOR: Medical; currently dir, very lge univ hosp; FACHA.

ADMINISTRATOR: Asst; R.N. (female); 10 years director, sev hosps; consider asst lge hosp only in MidW; middle forties.

COMPTROLLER: 3 years, a/c, 400 bed hosp; 5 years, comptroller, 175 bd gen hosp; seeks comptrollership includ'g budgets, stock room controls, hosps 250 beds; East, West Coasts, New Eng; Member AAHA.

PATHOLOGIST: Trn'd univ hosp; past yr ass't path, import tchg hosp of outstanding grp med specialists; Diplomate, Path Anatomy, Clin Path.

PURCHASING AGENT: 10 years, dir, purchases, 700 bed univ hosp; eminently qualified.

RADIOLOGIST: 31; Diplomate, Diagnostic Therapy & Isotopes; seeks west coast; lic'd Calif; DC; DND.

RADIOLOGIST: 30; M.D., Arkansas; Dipl. Diagnostic & Therapy; sev yrs exper'd; any locality, prefers Arkansas; lic'd Ark, Kan, Texas.

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